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COGME

COUNCIL ON GRADUATE MEDICAL EDUCATION

PUBLIC HEARING

November 19-20, 1987
Bethesda, Maryland

COMPLETED

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Professions
Division of Medicine

ORIGINAL

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COGME

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HRP-0907157

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Professions
Division of Medicine

DEDICATION

This volume is dedicated to the memory of Malcolm Lee Peterson, M.D. At the time of the Public Hearing, Dr. Peterson was Acting Assistant Chief Medical Director for Geriatrics and Extended Care of the Veterans Administration. Through much of the first year of the Council on Graduate Medical Education, he served as the alternate representative for the Veterans Administration. His contributions were far-reaching, visionary, thoughtful and sensitive. The Public Hearing of the Council was his last public service. He is very much missed.

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ACKNOWLEDGEMENT

The Public Hearing represented a critical step in obtaining the broadest possible range of input and views to the Council on Graduate Medical Education, as part of the process in developing its first report to the Secretary and the Congress.

Neal A. Vanselow, M.D., Chair, and David Satcher, M.D., Ph.D., Vice Chair, presided over the hearing. The quality and depth of the testimony of the witnesses and the lively and constructive dialogue between the presenters and members of the Council were evidence of the success of the Public Hearing. For this, we must thank the individuals and organizations who provided their testimony on the concerns currently facing graduate medical education.

Overall direction and coordination of the Public Hearing were provided by its Chairperson, Dr. Neal Vanselow, and Mr. Paul M. Schwab, Executive Secretary to the Council and Deputy Director, Bureau of Health Professions, Health Resources and Services Administration. Technical support to the Public Hearing, as to the Council generally was coordinated by Dr. F. Lawrence Clare, Program Staff Coordinator to the Council for the Bureau of Health Professions, and Director of the Office of Graduate Medical Education and Data Analysis of the Division of Medicine, Bureau of Health Professions.

Staff to the Council was provided largely by the Division of Medicine, Donald L. Weaver, M.D., Director: Ms. Magdalena Miranda was staff liaison to the Foreign Medical Graduates Subcommittee, and Ms. Brenda Selser provided further staff support to that subcommittee. Mr. Jerald M. Katzoff was staff liaison to the Physician Manpower Subcommittee, and Dr. Clare also served as staff liaison to the GME Programs and Financing Subcommittee. Dr. John Drabek of the Office of Data Analysis and Management, Bureau of Health Professions provided additional technical support, primarily in the area of physician manpower.

Program and administrative staff support was provided by Ms. Idelle Price Smith, Mr. Ronald L. Craig and Ms. Patsy McLain, of the Office of Graduate Medical Education and Data Analysis, Division of Medicine. Additional logistical coordination was provided under contract by The Circle, Inc.

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Background

The Council on Graduate Medical Education (COGME) was established by Public Law 99-272, the "Consolidated Omnibus Budget Reconciliation Act of 1985." This legislation established Part H of the Public Health Service Act, and authorized the Council under a new section 799, "Council on Graduate Medical Education." This section authorizes the Council through September 30, 1996. The Secretary signed the charter for the Council on June 6, 1986.

The Council is composed of fourteen private members and three Federal government representatives. The private appointees include six representatives of practicing primary care physicians, national and specialty physicians organization, foreign medical graduates, and medical student and house associations. Four were appointed as representatives of schools of medicine and osteopathy, and public and private teaching hospitals. The remaining four were representatives of health insurers, business, and labor. The three Federal government representatives are the Assistant Secretary for Health or his designee, currently the Administrator of Health Resources and Services Administration; the Chief Medical Director of the Veterans Administration; and the Administrator of the Health Care Financing Administration.

Prior to July 1, 1988 and every three years thereafter, The Council is to provide and make recommendations to the Secretary of the Department of Health and Human Services; the U.S. Senate Committee on Labor and Human Resources, and Committee on Finance; and the U.S. House of Representatives Committee on Energy and Commerce, and Committee on Ways and Means.

These matters extend to such issues as: specialty shortages and excesses; access to health professions opportunities and services, issues concerning Foreign Medical Graduates; financing GME; and medical education programs.

The first Council Meeting was held in Washington, D.C. on December 4 and 5, 1986. Neal A. Vanselow, M.D., Vice President for Health Sciences, University of Minnesota, was elected Chairman and David Satcher, M.D., Ph.D., President, Meharry Medical College, was elected Vice Chairman. Further Council meetings were held on March 17-18, June 29-30, and October 5-6, 1987, and February 17-19, 1988.

Three subcommittees were established to operationalize the Council's activities for its first report: (1) physician manpower, (2) foreign medical graduates, and (3) graduate medical education programs and financing. These subcommittees met separately on the first day of each of the Council meetings. In addition, each subcommittee held a one-day Special Meeting between August 28 and September 2, 1987.

To facilitate its work, the subcommittees first developed a list of issues to guide their deliberations toward reaching conclusions and making recommendations to be considered by the plenary Council for its first report. The subcommittees developed programs featuring expert presentations and papers as a means of providing their members with state-of-the-art information in their respective areas. The plenary meetings featured major speakers and an information base for the Council as a whole.

The Public Hearing offered opportunities to the widest possible range of interested individuals and organizations to present their views and recommendations to the Council. Testimony focused on the issues previously reviewed and approved by the Council on June 30, 1987, and on tentative conclusions and recommendations developed by the subcommittees and approved in draft by the Council on October 6, 1987. Thus, the Public Hearing was viewed by the Council as an opportunity to obtain a broad span of views concerning issues and policies from a comprehensive variety of interested organizations and individuals.

A total of 46 individuals representing 50 organizations participated in the Public Hearing on November 19 and 20, 1987. In addition, the Council received written testimony from 14 individuals and organizations who were not able to be present at the Hearing. Highlights of the testimony covered such areas as the Council's Principles, the health care needs of the underserved, minority representation in medicine, primary care, resident training in ambulatory settings, measuring the Adequacy of Physician Manpower, physician surplus and consequences, financial support for FMG residents, and resident substitution.

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COUNCIL ON GRADUATE

MEDICAL EDUCATION

PUBLIC HEARING

NOVEMBER 19-20, 1987

BETHESDA, MARYLAND

XVI

AAPA
American Academy of Physician Assistants

AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS
1117 North 19th Street • Arlington, Virginia 22209 • 703/525-4200

SUMMARY OF TESTIMONY

COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)

1. REDUCING THE SIZE OF GRADUATE MEDICAL EDUCATION PROGRAMS AND/OR THE REMOVAL OF FOREIGN MEDICAL GRADUATES FROM GME PROGRAMS WILL REQUIRE HOSPITALS TO SECURE OTHER HEALTH CARE PROVIDERS TO CARE FOR PATIENTS PREVIOUSLY CARED FOR BY RESIDENTS.

2. THE FMG SUBCOMMITTEE HEARD TESTIMONY FROM TWO WITNESSES REPRESENTING INSTITUTIONS THAT HAVE ALREADY VOLUNTARILY DECREASED THE SIZE OF THEIR RESIDENCY PROGRAMS. BOTH INSTITUTIONS HAVE HIRED PHYSICIAN ASSISTANTS AS HOUSE STAFF TO CARE FOR THE PATIENTS PREVIOUSLY CARED FOR BY RESIDENTS.

3. QUALITY OF CARE AND COST-EFFECTIVENESS OF CARE WERE MAINTAINED AFTER TRANSITION FROM RESIDENTS TO PA HOUSE STAFF. PRINCIPAL CONCERN OF WITNESSES WAS AVAILABILITY OF PAs AND MEDICARE REIMBURSEMENT POLICIES REGARDING PA SERVICES.

4. DESPITE THE "PHYSICIAN GLUT" AN UNPRECEDENTED DEMAND FOR PAs EXISTS. OPPORTUNITIES FOR PAs EXIST IN VIRTUALLY EVERY MEDICAL SPECIALTY WITH PARTICULARLY HIGH DEMAND FOR PAs WITH SURGICAL AND PRIMARY CARE EXPERIENCE.

5. ON JANUARY 1, 1987 MEDICARE LAW WAS CHANGED TO PROVIDE FOR COVERAGE OF PA SERVICES PROVIDED IN A HOSPITAL. PAYMENT IS ON A DISCOUNTED FEE BASIS WITH PAYMENT TO THE EMPLOYER OF THE PA.

6. THE ACADEMY STRONGLY SUPPORTS RECOMMENDATION 1.A OF THE SUBCOMMITTEE ON FOREIGN MEDICAL GRADUATES THAT REDUCTIONS IN THE FINANCING OF GME PROGRAMS NOT BE UNDERTAKEN UNTIL ADEQUATE ALTERNATIVES FOR DELIVERING HEALTH CARE TO THE MEDICALLY INDIGENT ARE IN PLACE.

7. THE ACADEMY STRONGLY SUPPORTS RECOMMENDATION 1(A)(d) THAT PROVISIONS SHOULD BE MADE FOR EXPANDING EDUCATIONAL PROGRAMS FOR ALTERNATIVE HEALTH CARE PROVIDERS.

8. THE ACADEMY URGES ADOPTION OF AN ADDITIONAL RECOMMENDATION THAT THE H.E.A.L. PROGRAM BE EXPANDED TO INCLUDE PHYSICIAN ASSISTANT STUDENTS AS ELIGIBLE APPLICANTS.

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ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE
TESTIMONY
BEFORE
COUNCIL ON GRADUATE MEDICAL EDUCATION
NOVEMBER 19, 1987

I am Gary Lepow, the Assistant Director at the Harris County Podiatric Residency Program in Houston, Texas and a practicing podiatric physician. I am pleased to have the opportunity to testify before COGME on behalf of the podiatric medical education community.

The preponderance of today's 10,000 podiatrists provide general podiatric medicine which entails preventive and primary podiatric medical care. They also provide rehabilitative care of foot conditions and functions, and perform surgical procedures.

Historically, the practices of podiatrists have been community-based in ambulatory settings, with podiatrists self-employed in solo office practices. More recently, however, podiatrists now participate in group practices, health maintenance organizations, preferred provider organizations, and individual practice associations.

The seven collegas of podiatric medical education prepare students in a four-year program for one to three years graduate training in general podiatric medicine, podopediatrics, podogeriatrics, orthopedics/biomechanics, podiatric sports medicine and podiatric surgery, for certification by the podiatric medical specialty boards.

As of academic year 1986-87, 454 residents were training in podiatric graduate programs located in 171 institutions in 34 states. This number of institutions includes 31 Veterans Administration Hospitals.

The decreases in podiatric residency positions available, and the decreases in the number of residency programs, 1986-87, due principally to the lack of funding for graduate training and the increase in hospital closures, have served as major barriers in the podiatric medical education process.

Further, the number of new podiatrists entering the profession, 1986-2020,is projected to decrease from 605 to 575 annually. This decrease will be due primarily to the projected decrease in the 18-24 year olds, and in the college population.

Association of Colleges of Podiatric Medicine
Testimony before Council on Graduate Medical Education
November 19, 1987

The hazards of projecting the health care needs, however, could have a deleterious effect upon the future of this Nation, for in the flurry of the Nation's health policy decisions for the 21st decade, the outcomes of statistical manipulation or econometric model, and the underlying assumptions could be taken as actual fact.

Without the benefit of crystal ball, the podiatric medical education community assumes that, for the near future, the U.S. primary health care model will prevail, and thus, will require professionally trained primary care providers. Therefore, the podiatric medical education community proposes

- CONTINUED EMPHASIS UPON PRIMARY HEALTH CARE

To be responsive to the Nation's health care needs, it must ensure an adequate number of primary care providers through support of primary care education and training.

- CONTINUED USE OF CURRENT SCHEME OF FINANCING TIED TO SERVICE

Any manipulation in the scheme of financing graduate education, without special care, would contribute further to the erosion of the financial base for health professions graduate education.

- CONTNUED PHS PROGRAMS IN SUPPORT OF PRIMARY CARE EDUCATION AND TRAINING

Despite the growing perception of the greater relevance of primary rather than tertiary care in today's health care system, without the establishment of a sound financial base for education and training in primary care, the support system should continue as a grant and contract program.

NUMBER OF
RESIDENCY TRAINING PROGRAMS and FIRST YEAR POSITIONS
and
NUMBER OF COLLEGE OF PODIATRIC MEDICAL GRADUATES
1975-76 to 1986-87

NUMBER OF:	1987/ 1988	1986/ 1987	1985/ 1986	1984/ 1985	1983/ 1984	1982/ 1983	1981/ 1982	1980/ 1981	1979/ 1980	1978/ 1979	1977 1978
CPME Approved Residency Programs	-	167	155	153	136	139	128	129	128	131	115
First-year Residency Positions	-	435	448	411	378	382	362	372	365	346	321
CPM Graduates	-	612	586	607	631	599	597	577	572	543	479
RATIO:											
CPM Graduates to First-year Residency Positions		1.4: 1.0	1.3: 1.0	1.5: 1.0	1.7: 1.0	1.6: 1.0	1.6: 1.0	1.6: 1.0	1.6: 1.0	1.6: 1.0	1.5: 1.0

Sources: Number of Residency Programs and First-year Residency Positions: Council on Podiatric Medical Education, APMA

Number of CPM Graduates: Colleges of Podiatric Medicine Annual Reports to AACPM

Office of Research and Policy Analysis, AACPM
American Association of Colleges
of Podiatric Medicine
May 1987

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University of Colorado Health Sciences Center

School of Medicine

4200 East Ninth Avenue
Denver, Colorado 80262

A NATIONAL "ASSOCIATE RESIDENT" PROGRAM: AN ALL-PURPOSE SOLUTION TO HEALTH MANPOWER PROBLEMS

Henry K. Silver, M.D. and Patricia A. McAtee, Ph.D.

SUMMARY

I. PROPOSAL: We propose that the Council on Graduate Medical Education endorse the widespread utilization of "associate residents" to help resolve several of the nation's major health manpower problems.

II. WHO ARE "ASSOCIATE RESIDENTS"?: Associate residents are specially-prepared physician assistants and nurse practitioners who have received an additional short period of training in a specific medical specialty or subspecialty. They have the skills and competence comparable to that of first year physician residents in providing much of the care and many of the services patients require.

III. WHAT WILL BE THE RESULT OF THE WIDESPREAD UTILIZATION OF ASSOCIATE RESIDENTS ?:

A. When associate residents substitute on a one-to-one ratio for first year physician residents in training programs in specialties in which there are surpluses of practicing specialists, fewer physician houseofficers are required to provide the services needed for the care of hospitalized patients. Extensive utilization of associate residents in place of first year physician residents will produce an eventual reduction of thousands of available positions for residents with the result that many fewer residents will aquire the training to become practicing specialists. This, in turn, will produce a significant reduction in the oversupply of physicians.

B. The presence of fewer specialists in practice will result in a cost saving of scores of millions of dollars.

C. In housestaff training programs in which houseofficers are grossly overworked, adding associate residents to assist in providing patient care will enhance the quality of training of the physician houseofficers.

D. In specialties with an undersupply of practicing specialists, associate residents could join physicians as their associates in practice to assist them in meeting unmet patient needs.

E. Expansion of the role of nurse practitioners so they can function as associate residents will result in better utilization of nursing talent and increase recruitment and greater retention of registered nurses.

IV. WHAT STEPS ARE NOW NECESSARY TO FULLY IMPLEMENT A NATIONAL ASSOCIATE RESIDENT PROGRAM?: In addition to having the Council of Graduate Medical Education endorse the widespread utilizaton of associate residents, we recommend 1) the appointment of a national advisory committee to define the course of study and curriculae of programs to prepare associate residents and to define their functions and scope of practice; 2) establishing appropriate training programs to prepare associate residents; and 3) establishing a national clearing house for associate residents similar to the one presently in operation to place graduating medical students in appropriate resident training programs.

CONCLUSION: The program we have described should be one of several solutions that are utilized to solve the nation's health manpower problems.

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ASSOCIATION OF ACADEMIC HEALTH CENTERS

COUNCIL ON GRADUATE MEDICAL EDUCATION

Public Hearing, November 19, 1987

Mr. Chairman and members of the council, I am Dr. Clayton Rich, Provost and Vice President for Health Sciences, University of Oklahoma. I am also the chairman-elect of the Association of Academic Health Centers, and it is in this capacity that I am pleased to have the opportunity of presenting to you the views of the association's board of directors on a number of issues in front of this council.

The board of directors is the elected governing body of the Association of Academic Health Centers. The association represents approximately one hundred American institutions of higher education, whose chief administrative officers -- presidents, chancellors, vice presidents for health affairs and others -- share with the deans of their respective health professions schools (medicine, dentistry, nursing, etc.,) and with the directors of their principal teaching hospitals the responsibility for those institutions' educational, research and patient care missions, and for their fiscal stability.

1. FINANCING OF GRADUATE MEDICAL EDUCATION

With the introduction of the prospective payment system for Medicare patients, the Congress has reaffirmed the legitimacy of financing medical education through revenues for patient services. We believe that this method of financing is appropriate and should be continued, at least until a better method, assuring continuity of support from the public sector is agreed upon by all interested parties. We also recognize the difficulties the government is experiencing in balancing the budget and have accepted reasonable limitations in the number of years of residency which ought to be financed under the Medicare program.

As you know, these principles are embodied in current federal legislation. Each year we witness prolonged discussions in Congress and in the Administration as to the amount of Medicare and Medicaid funds to be provided and the formulae to be used to pay hospitals for the costs they incur because of graduate medical education programs. We watch these negotiations over payments with some trepidation, because the trend has been a decline in the level of support, leaving to the institutions the onus of bearing an ever-larger portion of the cost -- a task which has become increasingly difficult at a time when competition prevails in the marketplace for health care services.

Competition in the health care market, new technologies and, to some extent, the prospective payment system, have combined to change the pattern of health care delivery. Patients stay in the hospitals for a shorter time and those admitted are more seriously ill. The result is that the exposure of graduate medical students to the full range of patient care is no longer available solely through the inpatient hospital service. These circumstances, plus the application of new technologies that permit some diseases to be treated on an ambulatory basis, have made it necessary that graduate medical education programs, traditionally located in the teaching hospital, utilize ambulatory sites as well.

Medicare's mechanisms are geared primarily to pay for graduate medical education costs incurred by the hospitals and are inadequate for costs incurred by entities, other than hospitals, which provide ambulatory health care services. There is, therefore, a penalty to be paid in training students in ambulatory care programs not related to hospitals, even though primary care specialties, which require exposure to ambulatory practice, represent an area of great need in the overall manpower structure of our health-care system.

We urge the council to recommend that all graduate medical education programs, not just those paid by or through hospitals, should be included in the mechanism for Medicare direct payments. The current Medicare and Medicaid provisions, which rely primarily on payments through the secondary and tertiary care hospitals, should be modified accordingly.

There have been suggestions that income derived from faculty practice should be tapped for paying part of the cost of graduate medical education. As we stated above, we firmly believe funding of graduate medical education to be a societal responsibility and that a federal role in financing it should not be abdicated. It is also important to recognize that faculty practice income already pays for educational and research programs of many institutions.

2. ACCOUNTABILITY OF THE CERTIFICATION PROCESS

The requirements for medical specialty certification are mandated by each of twenty-three specialty certifying boards and twenty-three residency review committees. These bodies determine the length of time residents must spend in training and the nature and content of the graduate medical education programs. These boards are not required to have their policy reviewed or approved by any other authority. Recent actions lengthening the time required for certification and stipulating expansion of graduate medical education programs in areas such as clinical research, have been questioned by several organizations representing medical practitioners, hospitals and medical education.

Our concern, as representatives of academic health centers, is that although our centers' hospitals and faculty provide the resources to conduct residency programs, these institutions have no input in the process.

We believe that there should be a method for overall accountability, and that those who set the requirements for the residency programs should be obligated to take into account the consequences of decisions to increase certification requirements. In making these decisions there should be ways to evaluate the gain in education versus other factors; there should be consideration of the institutions where training takes place; there should be justification of the necessity for increased training, including pilot programs and longitudinal studies to demonstrate the essentiality of such requirements.

I would emphasize that we are not suggesting regulating the boards -- and we would certainly strongly oppose any government oversight in the educational process -- but rather that there should be opportunities for greater accountability in what entails commitment of the resources of educational institutions.

Academic health centers have responsibility for the education and training of many health professionals besides physicians. We are concerned with similar issues that are occurring in programs other than medicine. We believe that medicine, which consumes the lion's share of the teaching resources of our institutions, should set the example for responsible behavior.

3. FOREIGN MEDICAL GRADUATES

It has been the basic position of our organization that graduate medical education of students that have obtained a medical degree from schools not accredited by the Liaison Committee on Medical Education or by the Bureau of Professional Education of the American Osteopathic Association should not be supported by Medicare and Medicaid funds unless these students' competence to enter our graduate medical education programs can be unequivocally established. We are concerned with two factors: quality and quantity. In our view, the issue is not one of rejecting foreign medical graduates by definition, but rather of maintaining the high quality of medical education in our country and of balancing the supply and demand of our health-care system with the output from LCME and BPE accredited schools.

Quality. Given the diversity of the training programs from which foreign medical graduates come, there should be mechanisms for obtaining satisfactory evidence of the students' competence -- including language skills, and clinical ability -- and not exclusively by way of written examinations which may or may not provide accurate means for evaluation. In the accredited schools these quality controls are exercised at the source by the process which evaluates whether or not the training programs can be expected to produce competent graduates. Furthermore, the accreditation process examines whether the schools have in place adequate means for evaluating those who complete the MD & DO programs. These schools do not rely entirely on one or two examinations, however comprehensive, but on the combination of examinations and continuous observation over a period of four years. The accreditation mechanism is not available to us to judge the adequacy of preparation of graduates of foreign medical schools.

We urge the council to consider these questions and to propose solutions. However, we do not believe that it would be feasible for the LCME or the BPE to accredit foreign schools and this approach is not one we would support. Foreign medical graduates who wish to enter our graduate training programs should be required to demonstrate as much competence as those who come from accredited institutions.

Another equally important aspect of the quality question is the concern that many hospitals that care for the poor depend on the service of foreign medical graduates in their residency programs. We strongly believe this to be wrong. Care of the poor should not be dependent on the availability of foreign medical graduates. Such a system condones dual standards which we reject. The poor should not be entrusted to the care of people whose qualifications are in doubt.

Quantity. Unless there is a degree of control over the number of graduates that enter the United States from schools not approved by the LCME and BPE, it would be useless to talk about reducing the surplus in the output from our accredited medical schools. It would not make sense to reduce enrollment in our medical schools with their well-defined system of quality control, without measures to stem the flow from outside.

To conclude, I submit to this council that the issues presented above represent serious problems that need to be addressed. Second-class care, second-class training, abuse of the system, all need attention and individual solutions that are equitable and fair to all concerned.

Thank you for your consideration.

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The Association of American Medical Colleges (AAMC), a century-old organization comprised of the country's 127 accredited medical schools and their students; more than 400 of the major teaching hospitals in the United States, and 85 academic and professional societies whose members are engaged in undergraduate and graduate medical education, patient care and biomedical research welcomes this opportunity to present its views on matters cognate to issues currently under consideration by the Council on Graduate Medical Education (CoGME). The composition of the AAMC makes obvious the Association's vital concern with the work of this Council.

CoGME's statutory mandate is one of extraordinary breadth. The access to the President and to the Congress that it provides for your recommendations gives the Council the opportunity to wield enormous influence on the future of American medical education and, thereby, on the health of the American people. In the light of the serious responsibilities that CoGME has shouldered, the AAMC applauds your wise decision to seek, through these two days of open hearings, the views of individuals, institutions and organizations with goals and objectives cognate to the CoGME mission.

Impelled by concerns similar to those that led the Congress to create CoGME---the aggregate supply of physicians for the U.S., their geographic and specialty distribution throughout the nation and the relationship of foreign medical graduates (FMGs) to the supply and distribution phenomena---the AAMC recently created a Task Force on Physician Supply that has been at work since May of 1987. The structure of this Task Force and the members of its Steering and four Working Committees---hereafter identified by the names of their

Chairmen---are shown in Attachment I. It is clear that the AAMC Task Force and CoGME are similarly organized.

The simultaneous examination of these issues by CoGME---through the eyes of the federal government---and by the AAMC Task Force---from the point of view of medical education---offers an unusual opportunity for two independent bodies to illuminate and enrich each others deliberations. As a result, areas of consensus will be reinforced and those of divergence explicated with the clarity that results from mutual understanding of the specific reasons for disagreement. Such an outcome should be most useful to government, to academe and the public at large. For this reason, the AAMC is following CoGME's progess attentively. The Association deeply appreciates Dr. Vanselow's gracious acceptance of our request to report on CoGME's progress to a plenary session of the AAMC's Annual Meeting last week and welcome this opportunity to reciprocate.

The Task Force and its Committees have been exploring the almost boundless terrain that the concept of "physician supply" opens. They are finding its topology complex and loci on its map interrelated in unexpected as well as expected ways. As yet, few conclusions have been reached or recommendations formulated. The program for the Association's annual meeting, held last week, was built around the theme of physician supply, with the intent of raising the consciousness of the entire community of medical educators to these issues and of giving the members of the Task Force the opportunity to interact with a broad spectrum of colleagues on this matter.

At the outset it is important to emphasize that the AAMC brings a unique perspective to a set of issues before CoGME: that of the medical educator, whose vocation is to transform undifferentiated baccalaureates into polished professional physicians. The members of our Association take enormous pride in what they have accomplished:

- increased access to undergraduate and graduate education and the threefold rate of increase in production of physicians since the end of World War II;
- provided more than half of the workforce for, and contributed at least proportionately to, the nation's spectacularly successful biomedical research effort; and
- added immeasurably to the capacity of the medical profession to deal effectively with disease, disability and premature death.

To medical educators, expanding is more congenial than limiting access to medical education; improving the environment for learning, more compelling than the mundane and practical considerations that predominate in today's public discussion. As our pluralistic society debates these issues of broad general concern, ours must be the voice that insistently reminds the participants that sound medical education is the foundation undergirding the nation's health care system.

This brings up the AAMC's first point, a mild demurrer from CoGME's 1st Principle that asserts that concern for the well being of the health professions, medical schools and teaching hospitals must be secondary to the primary concern of the Council for the health of the American people. The AAMC views these two objects of concerns---one dubbed primary, the other secondary--- while being related as being fundamentally different. One is an end; the other, a means to that end. It is not possible to have a healthy American people without healthy medical schools, healthy teaching hospitals, and well health professions. Therefore, the Association would have preferred that CoGME's 1st Principle recognized the cause-effect relationship of education to health. CoGME's Principle Nine speaks only to sufficient numbers of appropriately educated physicians. It does not, in the view of the AAMC, place the relationship between education and health status in proper perspective.

While few conclusions or recommendations have been recorded by the AAMC Task Force, CoGME's Principle Five, favoring where possible, private sector solutions, struck a resonant note. Both the Farber and Rabkin Committees have concluded that individual voluntary decisions and choices, responsive to a wide range of incentives and disincentives, should play the major role in modulating physician supply and distribution at every stage in the educational process; and that informed decisions require the collection and publication, at timely intervals, of comprehensive and accurate trend data on all aspects of physician supply. This conclusion is implicit in the concept of a private sector solution, a process that the economists call "perfecting the market".

A quick review of the status of affairs with the Working Committees of the AAMC Task Force reveals the following.

The AAMC's recently published report entitled "Physicians for the Twenty-First Century, the Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine," and better known as the GPEP Report, was the distillate of a massive study of the character of medical education, the educational preparation for it and both the immediate and life-long educational requirements that the physician must meet. This Report has provided substantial impetus for fundamental changes in the prevailing concepts of what constitutes good medical education. The state of flux induced by the GPEP Report has, in some ways, made even more complicated the task of Dr. Farber's group as it faces the many new, perplexing and first order questions encompassed in its charge.

The Committee's review of data on physician supply clearly indicates that, since 1950, the number of physicians in active practice has increased more rapidly than the population and that if the present rate of production is maintained, the number will continue to increase disproportionately for the next 25-30 years. The Committee is pondering issues that need illumination before judgements can be made about the meaning of supply data:

- What effect on matriculants and graduates can be projected under various assumptions about the size and quality of the applicant pool and altered academic standards for matriculation?
- What constitutes an adequate supply of physicians under the medical as well as the socio-politico-economic circumstances likely to prevail during the next several decades? What are the advantages and disadvantages to patients, to physicians, to society, to the economy, to government of too many physicians? Are the answers to these questions, however important to other segments of society, a proper or central concern for medical educators?
- How can the number of underrepresented minority physicians be increased, a question concordant with CoGME Principle Three.
- Should the undergraduate education process deliberately seek to influence student preference between generalist and specialist modes of practice, and if so, by what means?

The Rabkin Committee, as it studies the impact of physician supply issues on residency training, is immersed in a plethora of issues that confront graduate medical education. For example,

- the preservation of education as the primary and essential goal of residency training.
- the development and financing of alternative mechanisms to meet service loads not properly assignable to residents.
- the development and financing of high quality educational programs for residents in non-hospital settings.
- the promotion of increased emphasis on primary care resident education to meet societal needs.

The Rabkin Committee will undoubtedly build on the conclusions and recommendations of the several AAMC advisory committees that have plowed this terrain recently, particularly with respect to the financing questions. You may recall that the AAMC's Report by a Committee on Financing Graduate Medical Education issued in 1986, probed in depth a great many alternatives, but finally opted for maintaining the status quo on financing residency programs until a demonstrably better and fairer solution, with fewer downside risks, became available. Status quo, in this sense, means that residency program funding, in principle, continues to be derived from hospital revenues through whatever period is prescribed by primary specialty boards as a precondition for board certification. The statutory Medicare adjustments that authorized one additional year of funding at full cost and additional years of residency or fellowship funding at half cost are acceptable political applications of that principle. Attachment II summarizes the Association's conceptual framework and most recent official positions on the financing of graduate medical education.

The set of issues related to foreign medical students and graduates that fall within the purview of Dr. Moy's Committee include long-standing AAMC preoccupations about the basic competence of the nation's physician pool. A brief review of AAMC participation in activities related to foreign medical graduates is embodied in Attachment III. Students in the LCME-accredited schools that make up the AAMC are continuously under the close surveillance of a faculty whose education, experience and achievements are matters of record. The graduation of students by these faculties coupled with the performance of students on a nationally standardized examination provide assurance of the competence of the graduates of our medical schools. A perennial problem has been how to measure the qualifications for entry into graduate medical education of physicians educated in the myriad foreign medical schools about which little is known. The Moy Committee is looking at the prevailing and proposed solutions, including hands-on clinical skills evaluation. It is also concerned:

- about the acceptability of the education provided by GME programs that have not been attractive to American graduates and that have been able to recruit only FMGs,
- about the needs of the large Hispanic populations in the USA for bilingual physicians; and
- about the obligation of graduate medical education in the United States to meet the needs of foreign countries for specialist physicians and medical educators.

As an aside, it should be known that the deans and faculties of AAMC schools cringe at the very thought of limiting the access of able American students to first rate U.S. medical schools, while far less qualified students are provided ways for entering medical practice with credentials from recent-vintage for-profit Caribbean medical schools. The AAMC was pleased to learn that CoGME did not endorse the proposal that a way be found for American accreditation of foreign medical schools.

Finally, the AAMC Task Force has extended its scope beyond CoGME's to examine the future role of our academic medical centers in the education and training of biomedical scientists, a function inseparably linked to the conduct of biomedical research. The Korn Committee has affirmed the critical importance of both the research and the research training programs in the biomedical sciences conducted in our institutions:

- o to advance science;
- o to improve medical practice; and
- o to replenish faculty.

The remarkable pace of advance in biomedical science in the last quarter century has exposed extraordinary vistas for progress against disease, disability and premature death, and the Committee has recommended that the Task Force strongly endorse expanded Federal investments in biomedical research. It has also articulated the view that the research training components of the national scientific enterprise be maintained at least at current levels, irrespective of any adjustments in medical school programs and faculty numbers that may be indicated on the basis of physician supply issues. This Committee intends to develop a set of proposals and recommendations on now to insure a steady flow of talented students into graduate education and training programs and on to research careers in the basic and clinical biomedical sciences.

The AAMC hopes that this that this all-too-brief synopsis of the Association's views cognate to CoGME concerns clarifies its positions on these important issues that you are confronting. The AAMC will be glad to answer any questions .

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TESTIMONY OF

STANFORD A. ROMAN, M.D.
DEAN

OF THE

MOREHOUSE SCHOOL OF MEDICINE
ATLANTA, GEORGIA

BEFORE THE

COUNCIL ON GRADUATE MEDICAL EDUCATION

CONCERNING THE

FEDERAL GRADUATE MEDICAL EDUCATION PROGRAM

ON

NOVEMBER 19, 1987

Mr. Chairman, and members of the Council on Graduate Medical Education, I am pleased to appear before you today to discuss issues related to Graduate Medical Education.

The Association of Minority Health Professions Schools is comprised of the Meharry Medical College's Schools of Medicine and Dentistry in Nashville, Tennessee, of which the distinguished Dr. David Satcher, who is a COGME councilor, is President; the Charles R. Drew Postgraduate Medical School in Los Angeles, California; the Morehouse School of Medicine in Atlanta, Georgia; the Tuskegee University School of Veterinary Medicine in Tuskegee, Alabama; the Xavier University College of Pharmacy in New Orleans, Louisiana; the Florida A&M University College of Pharmacy in Tallahassee, Florida; and the Texas Southern University College of Pharmacy and Health Sciences in Houston, Texas. With the exception of the health professions schools of Howard University, our association represents all of the black health professions schools in the United States. Each of our institutions rely heavily upon federal institutional, research, and student aid support. The medical schools of our association that are affiliated with health care facilities and teaching hospitals are profoundly affected by federal policy related to Graduate Medical Education. The collective and individual goals of our institutions to increase the number of black and other minority health professionals in the nation will be affected greatly by the initiatives and recommendations established by your Council.

Our institutions have made a significant historical contribution to improving the health status of blacks and other minorities in the nation, and in increasing the number of black health professionals to serve in underserved minority communities. In fact, the eight schools of our association have trained 50% of the nation's black physicians, dentists and pharmacists, and 90% of the nation's black veterinarians. However, although blacks comprise roughly 12% of the U.S. population, only about 3% of the nation's physicians, dentists, and pharmacists are black, and only 2% of the nation's veterinarians are black. We are very proud of the accomplishments of our institutions in increasing the number of blacks in medicine and the other health professions, but the figures I have just cited demonstrate how far behind we still are. Those numbers also provide a reflection of just how fragile our national capability is to address the disparity in health status among blacks when compared to whites. If these schools had not been established, or if any of them were to close their doors, just imagine how much further we would be behind -- much more than we are right now.

In 1985, then Department of Health and Human Services Secretary Margaret Heckler released the HHS Task Force Report on Black and Minority Health that confirmed the critical health status disparity that exists in this country among blacks when compared to whites. A black infant is twice as likely to die in its first year than is a white infant. Adjusted for age, 60,000 excess deaths occur among blacks each year than compared to whites, and life expectancy for blacks is much lower for blacks than whites. In fact, in my home State of Georgia, in some rural counties, the life expectancy for blacks is less than that of blacks in Kenya, Africa. The HHS Secretary's task force report refocused the nation's attention on these critical disparities, and set the tone for a national commitment to improve this woeful situation. Unfortunately, federal policy has been slow in responding to the recommendations of the report.

A cornerstone recommendation of the task force report advised that one of the best methods of improving health status among blacks and other minorities is to increase the number of minority health professionals to meet the desperate health care needs of this underserved population. Various studies have been completed, one most noteable was prepared by Dr. Steven Keith who now serves as health adviser to Senator Kennedy's Human Resources Committee, that demonstrates that minority physicians are much more likely than their majority counterparts to serve in primary care specialties, in underserved areas. A survey of Meharry Medical School graduates confirms that 75% continue on to serve in underserved areas.

The major point I wish to make by this discussion is that, as a nation we are faced with a glaring, unforgivable health status disparity among blacks when compared to whites. A fundamental means of addressing this disparity is to establish a national commitment to significantly increase the representation of blacks and other minorities in medicine and other health professions, and eliminate the barriers that prevent bright young blacks from seeking health professions careers. This special national situation calls for a special federal response in terms of policy, financing, and support.

Several issues that the Council has asked organizations to comment on regarding manpower are of concern to our association.

The Council asks these questions:

Q: Assuming a continuation of current policies and present trends, what conclusions can be drawn about the adequacy of the expected supply of physicians over the next two decades?

AMHPS A: If current policy continues, our association believes there will be continued under-representation of minorities in the health professions, and continued declining enrollment and acceptance rates of blacks and other minorities in health professions schools. The supply of physicians will continue to reflect an oversupply of highly paid specialists, and an undersupply of those willing to provide primary care in underserved areas.

Q: What policy changes in the public and private sectors are recommended to deal with any projected imbalances in physician supply?

AMHPS A: Foremost, is to remove the existing financial barriers that prevent, or discourage young bright individuals who are willing to serve in underserved areas from seeking health professions education. As well, reward teaching hospitals for emphasizing programs that train individuals to practice primary care in underserved areas. Further, expand Graduate Medical Education reimbursement to ambulatory settings to encourage patient care teaching in these important surroundings. And, better reward those health care institutions that treat a disproportionate share of poor people, thus not deriving a substantial revenue base from patient care.

Q: What impact will these recommendations have on the quality of health care, costs, access, minority representation, and physician function?

AMHPS A: Our association believes that implementation of the policies I have just recommended will facilitate an increase in the number of minorites in medicine and other health professions, serving in primary care in underserved areas. It should go without saying that access to care will be improved significantly by these recommendations, and that can only lead to better quality, lower costs, and improved health status among blacks and other minorities.

The Association of Minority Health Professions Schools urges that the Council on Graduate Medical Education make a sincere, concerted effort to recommend changes in Graduate Medical Education policy that will increase the numbers of minorities in medicine and provide improved patient care at teaching hospitals. Finally, we urge that the COGME closely review our national needs for the future, and present policy options to address our health professions, and health care needs for those years.

Thank you for the opportunity to present the views of the Association of Minority Health Professions Schools. I am pleased to respond to any questions you may have.

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THE NATIONAL ASSOCIATION OF MEDICAL MINORITY EDUCATORS

TESTIMONY BEFORE THE COUNCIL ON GRADUATE MEDICAL EDUCATION

NOVEMBER 19, 1987

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The National Association of Medical Minority Educators
Testimony before the Council on Graduate Medical Education
November 19, 1987

The National Association of Medical Minority Educators (NAMME) appreciates this opportunity to address the Council on Graduate Medical Education (COGME), for we feel it is imperative that recommendations made to the Secretary of the Department of Health and Human Services relative to physician manpower without evidence of a strong commitment to minorities and the medically underserved fail to accurately reflect those issues that should impact policy.

We concur with the those COGME principles that conclude that solutions developed without consideration of specific reference to targeted groups risk ignoring the barriers to access in graduate medical education, currently the experience of minorities. The barriers to access include the high cost of medical education; the high competition for specialty residencies; the lack of uniform affirmative action within medical school graduate education programs; and minority underrepresentation among medical school faculty resulting in few role models and mentors.

We can not discuss these barriers in isolation. Not only are there comparatively few successes in residency placements, but there are comparatively few minority medical school graduates to seek placement. Graduation rates of minority students are influenced by similar factors to those that influence low numbers in graduate programs. In addition, Luke and Tudor conclude in their report on The Differential Analysis of U. S. Medical Schools with High and Low Minority Graduation Rates (September 1987) that students are affected by financial obligations, levels of academic preparedness and external family pressures. The academic preparation includes MCAT performance, especially in the quantitative and reading test, which are important measures in determining success in the completion of medical school. Intervention along the entire length of the educational pathway improves the potential for greater numbers of minorities to compete for and be successful in residency training programs.

Factors related to financial status significantly impact the initial choice of medicine as a career as well as the selection of specialty. We are well aware of the direct consequence of high indebtedness; but, there are the indirect cost as well. The most obvious indirect cost is the foregone earnings resulting from the lack of gainful employment during many years of education. The high cost of medical education creates financially more compromised medical minority school graduates, who find themselves unable to access residencies at rates comparable to that of their majority counterparts. This high cost of medical education plus the delayed earning potential diminishes the prospects of attracting numbers of minority students seeking medicine. Repayment of loans during the residency years is an added financial burden to an already financially overburdened minority medical student. Since minority practitioners can only survive and thrive serving their respective minority populations, and since the need for minority practitioners is best demonstrated in their respective minority population, it is not surprising that the financial burdens of medical education are even further compounded by practice site selection of medical minority graduates, usually into areas of poorer earning potential. Thus, the early years of practice with relatively large educational debt and a less lucrative forecast for earning potential is financially difficult to manage. All of which, not surprisingly, serve as a disincentive for minorities selecting medicine.

Nonetheless, the small pool of minority residents comprise a unique group of individuals. They, given access and removal of barriers, not only *will* serve the medically underserved, but they *wish* to serve them. Therefore, decreasing minority representation in graduate medical training programs directly impacts the recognized area of increasing health care delivery need which exist in the medically underserved populations. According to the most recent medical education report (JAMA, August 1987), black, non-Hispanic medical residents have remained around 4.5% for the last several years, in the face of marginal increases in medical school enrollment from 1986 to 1987, of 5 3% to 5.8% respectively. The numbers of other underrepresented minorities has either remained stable or declined. There is also a disproportionate underrepresentation in acquiring placement among all resident specialty offerings. Over the last three years blacks have declined in 15 of 28 specialty areas of residency training. What is of greater interest is that a decline in first year appointments of FMGs and an increase in new residency programs, did not translate into and increase in minority, blacks specifically, representation on a percentage basis.

It is interesting to note that with no appreciable increase in minority representation, the ability to serve any given population is also compromised. In the open market place, there will be few to treat the medically underserved in subspecialty areas, such as neonatology, or colon and rectal surgery. These two specialty examples are illustrative of anticipated delivery needs based on changing minority population demographics i.e. an increase in births and an dramatic increase in the aged. In fact census projections indicate that the black and Hispanic population is expected to increase to approximately 30% by the year 2030, while the number of black and Hispanic physicians is not projected to grow proportionately.

Achieving solutions to these problems must include affirmative programs that take into account the need to promote, protect and finance positions for minority graduates. The country should have a vested interest in this human resource. There should be enthusiastic support for expanding opportunities. But, those opportunities will remain limited until minority representataion on academic policy making bodies such as admissions, promotions, and residency selection committees is achieved. However, increasing academic role models is only a partial response. While it is true that a more supportive environment will address some of the problems, role models without a strong institutional commitment accomplishes very little, for the establishment of a cadre of role models is also dependent upon access to graduate medical education.

In addition to the need for aggressive affirmative action programs in residency training, a more aggressive approach to financially assist in the cost of a medical education is also needed. Basically, poor students who become physicians take care of poor patients and receive poor money. The system must recognize this and reinstate programs that promote loan forgiveness. Certainly, the financial burden will continue to negatively influence young people if left unchecked.

In conclusion, COGME must maximize this unique opportunity to bring to reality the quote from the Physicians for the 21st Century: report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine, "The opportunity to study medicine should be available to qualified individuals regardless of their sex, race, ethnic origin or financial status." NAMME's members, as faculty and administrators at health professions schools and who have direct reponsibility for minority issues, supports innovative approaches to accomplishing this objective. Blacks, Hispanics and other minorities must enjoy all rights and privileges of this profession. Through diversity in representation true excellence is achieved. Providing excellence in health care to a diverse population enhances excellence as a nation.

In closing we quote Sojourner Truth who said, "We do as much; we eat as much; we want as much.

Thank you.

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TESTIMONY OF THE
AMERICAN MEDICAL STUDENT ASSOCIATION
BEFORE THE
COUNCIL ON GRADUATE MEDICAL EDUCATION
NOVEMBER 19, 1987

The American Medical Student Association (AMSA) is the largest independent medical student organization in the country with over 35,000 student and 8,000 resident members nationwide. We appreciate this and every opportunity to contribute to the policy-making process regarding graduate medical education. As future physicians, we will be directly affected by changes in medical specialty training. In effect, we are that "expected supply of physicians" which the Council is scrutinizing.

AMSA is particularly interested in the issues before this committee because of our long-standing interest in enriching medical education and assuring access to quality health care for all. These commitments are evidenced by our involvement in initiating the National Health Service Corps, our development of a Health Promotion/Disease Prevention program which places students in medically underserved areas for an internship, and our study groups on for-profit medical care and the financing of medical education, and much more.

We would like to start by thanking the Council for its careful and thoughtful work in assessing the problems before us. Indeed many of AMSA's greatest concerns are already reflected in your proposed recommendations. You have pointed out the need for more primary care practitioners, the geographic maldistribution that exists, the need to recruit more minority students to medical fields, and the importance of altering manpower projections as the needs of society and the composition of the physician population change.

There are two related questions that we would like to address. First, is there a role for the U.S. government in financing graduate medical education (GME)? Second, how should we address the manpower needs of the nation, especially as related to health manpower shortage areas (HMSAs) and primary care in the face of an overall physician surplus?

Let me begin by rephrasing the first question. Instead of asking, "Is there a role for the U.S. government in financing GME?", let us ask, "How else will we deliver the health care now provided by interns and residents, particularly the 75% of indigent care that our residents now supply?" How else can we insure an adequate supply of primary care physicians? Are we doing our best at both of the above?

Clearly we are not doing our best at providing care to the indigent or insuring an adequate supply of primary care physicians. Despite the fact that we spend a larger percentage of our gross national product on health care than any other country, our mortality statistics are strikingly similar to a developing country. The United States ranks 15th in male life expectancy, 7th in female life expectancy, and 14th in infant mortality. The black infant mortality rate is twice that for the white population.

As the COGME manpower sub-committee has stated, there is a physician surplus in some specialty and geographic areas, yet there is a dearth of primary care givers, in particular, family practitioners. This shortage is accentuated in HMSAs. According to the Bureau of Health Professions 1987 figures, over 3 million urban and rural Americans live in HMSAs and do not have access to even the most basic care.

From our perspective as medical students, we see the geographic maldistribution as a reflection of the very personal choices that young physicians make as they complete their residencies. These observations are illustrated in a recent study by Langwell et al[1]. They showed that certain community characteristics like higher educational resources, higher socioeconomic markers, available health services, and climate determine which underserved communities are able to attract young physicians. In short, "many areas are unattractive to physicians, and they will continue to have a shortage of physicians" in spite of physician surpluses.

This work only weakly supported Newhouse's hypothesis that a surplus of physicians will result in a diffusion into HMSAs.[2] According to Langwell:

> Fifty-eight percent of non-metropolitan countries gained one or more young physicians (in the period studied, 1974 to 1978), 42% did not. Nearly 60% of counties that did not gain a physician had populations under 10,000.

AMSA agrees with the manpower sub-committee's determination that there may be a shortage of primary care physicians. However, it seems anomalous that COGME would indicate that there is an oversupply of physicians in pediatrics when nearly one-third of the nation's 35 million medically indigent patients are children. As the number of pediatricians increases, it seems appropriate to develop incentives to direct and encourage physicians to serve children in need.

As we grapple with the issues above, we must also address the question of quality medical education. You have stated in the recommended COGME principles that medical education is secondary to the health care needs of our citizens. We feel that this may be so in the short run, but quality health care for the people of the United States is dependent on quality medical education for physicians. We must insure that this education stresses the importance of social and ethical issues, clinical competence, and a responsibility to serve the community. These issues have already been studied in depth by GPEP (1984) and many others. AMSA sees no need for further study, but a call for action.

The second question we wish to addess is "How should we address the manpower needs of the nation, especially as related to HMSAs and primary care in the face of an overall physician surplus?" Keith, et al.[4], showed that minority physicians tend to practice in HMSAs in greater proportions than their white contemporaries (12% to 6%). Yet despite the proposed goal of having 16% minority enrollment by 1975, the latest AAMC data show that minorities comprised only 8.9% of the entering class last year (an increase of only 0.6% over the last decade).[5]

Perhaps more telling is the fact that between 1976 and 1986, the majority applicant pool decreased by 27.6%, while the minority applicant pool decreased by only 3.6%. In spite of this, during the same period, the minority applicant's chance of being accepted relative to a majority student declined. This data seems to indicate that minority students are applying to medical school in adequate numbers despite the lack of faculty role models and general social support structures.

In addition, the cost of medical education is skyrocketing. According to AAMC data, the average indebtedness of a medical school graduate in 1987 was over $36,000. Financing options for low and even moderate income students are limited. The increasing reliance on high interest HEAL loans is increasing the student's debt burden still further. Our fear that students will opt for higher paying non-primary care specialties and more financially rewarding locations in order to meet their loan payments is supported in part, by an AMA study conducted by Gloria Bazzoli.[6] She showed that as the proportion of debt that is HEAL-based increases, the proportion of residents planning to pursue primary care declines. AMSA also shares the concerns of Steven Shea, et al.[7], that the increasing debt burden may discourage low income and minority applicants from applying to medical school in the first place.

RECOMMENDATIONS

Our federal government must take a stronger pro-active role in solving these problems. Our country needs and deserves a unified program which insures the delivery of quality primary care and preventive measures to our medically indigent population, an adequate supply of primary care physicians and quality graduate medical education. History provides no evidence that the private sector is willing to adequately address these problems, and there is no reliable way of guranteeing they will take on this responsibility in the future.

Financial incentives should be put into place which: 1) support and reimburse cognitive skills to the same level as technical and procedural skills. 2) Promote primary care by providing financial support for medical education in the primary care setting. A relative value scale for reimbursement in the Medicare and Medicaid programs would lead the way for insurance companies to do the same. In addition the federal government must guarantee sufficient financial support to primary care residencies so as to provide adequate numbers of primary care physicians. 3) Reward residencies which emphasize out-patient clinical training, stress preventive medical skills and improve resident working conditions thereby insuring quality patient care. This should include incentives to hire ancillary help to reduce the resident "non-medical" workload and to decrease the total hours worked per week to reduce chronic fatigue.

As a nation we must reaffirm our commitment to recruiting physicians for HMSAs. The National Health Service Corps is an excellent way to do this, but the Corps and its recruiting mechanisms are grossly under-funded at this time. The Corps was recently reauthorized by Congress, but funding was denied for a new loan repayment program, not for lack of popular support in Congress, but because of the timing of the authorization relative to the appropriation bill. The NHSC and other loan forgiveness programs for those willing to serve in underserved areas or in primary care simply must be funded.

Additionally, there is a role for the federal government to play in assuring that greater numbers of minorities and other students from HMSAs enter the medical education system. These young people must be provided with the primary and secondary education they need to intellectually support a medical career. They must have financial and social supports to enable them to attend college and medical school. Medical students generally should not be forced to incur prohibitive debt loads which prevent them from practicing in the low income HMSAs. Our Congress has the responsibility to insure that equitable programs with equal access in all states are put in place to do this.

Thank you for your time.

P. Preston Reynolds, M.D., Ph.D
President

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Table I: Average Debt of Medical Graduates, 1981-85

Indebtedness Level	Year of Graduation				
	1981	1982	1983	1984	1985
	Number of Seniors				
$40,000-49,000	191	289	585	821	986
$50,000-59,000	41	106	201	378	569
$60,000-69,000	10	52	88	194	318
$70,000-79,000	5	15	45	110	178
> $80,000	1	6	35	98	305
> $40,000	248	468	954	1601	2356
> $60,000	16	73	168	402	801

Ref: Data obtained from questionnaires prepared by the Liaison Committee on Medical Education and the Association of American Medical Colleges.

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TESTIMONY BEFORE THE COUNCIL ON GRADUATE MEDICAL EDUCATION

BY

JANET FREEDMAN, M.D.

PRESIDENT, COMMITTEE OF INTERNS AND RESIDENTS

STIMONY BEFORE THE COUNCIL ON GRADUATE MEDICAL EDUCATION
BY
JANET FREEDMAN, M.D.
PRESIDENT, COMMITTEE OF INTERNS AND RESIDENTS

As President of the Committee of Interns and Residents, the union representing over 5,000 physicians-in-training in New York, New Jersey and Washington D.C, I am pleased to be here today. Over the years, residents have consistently advocated for improvements in the conditions of our work and the quality of care we deliver. Given the major changes proposed for residency programs, now more than ever, we are compelled to see that our interest and our patients' interests are addressed.

Over the last 50 years, health care delivery has undergone a "revolution". The amount of medical knowledge and almost daily changes in available technology have dramatically increased the demands on residents. Cost-containment strategies have created a myriad of paperwork. More acutely ill patients utilizing shorter hospital stays, combined with new diseases such as AIDS, have created a much more stressful and complicated work environment for physicians-in-training today.

Yet, our system of training physicians has not kept pace. It has been the public - not the medical profession - which has initiated major changes. Congress examined its reimbursement systems for financing residency programs and established this Council to propose changes. A New York grand jury investigation into a patient's death and a California state senator have challenged the quality of patient care provided by doctors working 36 hour shifts.

As each sector of our society affected by both the cost of and quality of our healthcare delivery proposes solutions and changes in their own interest, it is the role of government to protect the priorities of our society as a whole. The federal government, and Congress in particular, has a leading role to play in a review of the structure and content of residency programs. However, public decision makers have serious misconceptions about residency programs. An essential task of this Council, comprised almost entirely of doctors, is to advise Congress about who residents are and what we do, and to propose policies that accurately reflect the work of residents and the quality of health care they are able to provide to their patients.

What do residents do?

1. We do work. Lots of it. We provide essential medical services in the largest hospitals in the nation. The term "graduate medical education" is a misnomer. It creates an illusion in the minds of the public and public officials that we are passive recipients of classroom education at the expense of

patients and taxpayers. We are already physicians and are in training to become specialists. We have already completed 4 years of undergraduate education and 4 years of medical school. We spend 90% of our time in direct patient care, working 90-100 hours a week, and often more.

2. We do work on the most cost-efficient basis. No other health professional works as cheaply as we do. First-year residents earn a national average of $21,000, or little more than $4.00 an hour for their 100-hr. workweek. Substitution of our services is a very costly matter. The Health and Hospitals Corporation in New York City estimated a cost of $20 million to hire 1200 non-physician ancillary staff to replace resident labor if the proposed hours reduction took effect.

3. We do work that fills a societal void - providing the bulk of medical care to the nation's poor. The private voluntary teaching hospitals provide two times the bad debt/charity care of non-teaching hospitals. Public hospitals provide three times more.[1]

What do these facts mean for policy-setting?

First, we could not as a nation fulfill our mission of providing quality health care to all Americans without the medical services provided by residents in teaching hospitals. It is appropriate, therefore, to maintain Medicare funding for residency programs, and patient care revenues as the proper source of that funding.

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[1] New England Journal of Medicine: Vol. 313, No. 3, p161)

Second, there is one particular group of physicians who fill that societal responsibility more than any other - graduates of foreign medical schools. FMGs are concentrated in inner city hospitals. They go where their USMG colleagues have refused to go, both during residency and afterwards. That is a fact. However, it is a myth that these doctors are more poorly trained and provide medical care of lesser quality. Rather than discriminate on the basis of place of medical education, CIR has advocated for one examination for all medical graduates. We are pleased with the similar recommendation of the Subcommittee on Foreign Medical Graduates.

Third, as providers of health care services, physician training and medical research, our teaching hospitals are vital to our national system of health care delivery - now and for the future. The differential system for reimbursement to teaching hospitals is the right approach, and should be refined to further provide incentives for resident physicians to train and work in the areas most needed by society - socio-economically, geographically and by specialty.

Fourth, this Council must be careful in calling for private sector solutions which ignore the solutions currently being provided by the public sector. It is the public sector which sees health care for all as its mission, and it is through public money that the private sector can be influenced to carry its share.

Without comprehensive solutions, however, the public sector can't really fill that void in health care delivery. The call for some form of national health program is being issued throughout the country. Health Care policy makers need to hear it.

I have hardly deluged you with statistical data - I am sure others will do so. That data will be misinterpreted, however, unless this Council provides for Congress an accurate framework of the role of residents and teaching hospitals in our nation's health care delivery system.

Thank you for the opportunity to address you.

TESTIMONY BEFORE THE COUNCIL ON GRADUATE MEDICAL EDUCATION

BY

DAVID MARDER, M.D., PRESIDENT

NATIONAL FEDERATION OF HOUSESTAFF ORGANIZATIONS

I am Dr. David Marder, President of The National Federation of Housestaff Organizations. Our member organizations are leaders in their hospitals, their communities, and their states in improving residency programs and patient care. I am pleased to represent these efforts on a national level. On behalf of the NFHO, I welcome this opportunity today to share our ideas with you.

Two years ago, our efforts, among others, halted the wanton and thoughtless cuts proposed for the funding of residency programs. COBRA established guidelines for funding and the formation of this Council. Like many others, we saw this as an opportunity to formulate a policy which would make the needed reforms systematically and gradually, encouraging physicians to train and work in fields that society needs most.

As my colleague, Dr. Janet Freedman, previously noted: residents provide much of the acute medical care to the nation's poor. Thus, the needed comprehensive restructuring of residency programs must occur in the context of developing a national health program that provides access to quality care for all

Americans.

In the meantime, the following reforms make essential steps in that direction. I propose that the Council take these proposals as guidelines and use your staff and resources to develop them for Congress.

One of the underlying reasons for the cuts to residency programs is the premise that this nation has too many doctors. As COGME's Subcommittee on Physician Manpower points out, the essential answer to be sought in addressing this lies in solving the problem of the maldistribution of doctors -- geographically, socio-economically and by specialty. In order to influence the specialties and locations in which physicians choose to train and work, Congress should set funding priorities to certain teaching hospitals, to certain specialties and to programs which fill certain criteria. In particular:

1. Residency programs in hospitals which serve a disproportionate share of the medically indigent should be funded at a higher rate than those in other hospitals.

Public municipal teaching hospitals and private voluntary hospitals in medically underserved areas provide medical service to the nation's poor, a service not duplicated by other hospitals.

Just as Congress mandated the disproportionate share adjustment to DRG payments, it should assign a similar adjustment to direct and indirect payments for the funding of residency programs. Such positions should be weighted at a higher level just because they are in these hospitals.

Provisions should be made which target the funding to improving the salaries, benefits, working conditions, and training aspects of these residency programs, thereby enticing residents to choose these hospitals.

2. Residency programs which train physicians in primary care medicine and programs which train physicians in specialties where there is a shortage should receive funding at a higher rate than subspecialties.

In 1985, the House Subcommittee on Health and the Environment heard a proposal which gave phased-in incentives for primary care and disincentives for subspecialty training. The proposal had some specific problems, but the general idea addressed the maldistribution of physicians by speciality. In that approach, medical and surgical subspecialties were seen as the logical place, within the framework of Medicare funding of residency programs, from which to shift money away.

For purposes of further investigation, we propose family practice, internal medicine, pediatrics, ob/gyn, preventive medicine, and occupational medicine as primary care specialities; and psychiatry, geriatrics and rehabilitation medicine as specialties where there is a shortage.

Some subspecialty residency programs are called "fellowships"; others retain the name "residency." Many doctors working as fellows or as sub-specialty residents spend most of their time doing work essential to the hospital's ability to deliver services. Thus, the disproportionate share adjustment must apply here as well. Hospitals in medically underserved areas should get enticements for fellows to come there. In these areas, the fellows are often the only subspecialists to whom these patients have access.

3. **Residency programs which have a significant portion of their training in out-patient, ambulatory care settings should be funded at a higher rate.**

Clinics and other outpatient facilities are important sites of medical training and practice. We encourage the phase-in of funding for such training sites. This will encourage the building of ambulatory/primary care services in areas where the teaching hospital emergency room is the neighborhood doctor's office.

One of the results of the concentration of U.S. medicine in the acute care medical centers and in subspecialties is the breakdown of the primary care network. Nowhere is this more obvious than in medically underserved areas. For example, New York City's public hospitals provide over 5 million outpatient visits a year to the city's poor and near poor. These same hospitals often work at over 100% bed capacity - if guerneys in the halls are counted.

The shift from emphasizing acute speciality medicine to primary ambulatory care needs to be done a step at a time. In the meantime, before such a network is built, we must continue to support the care where it is currently provided - in the teaching hospitals.

4. **Residency programs which have a viable affirmative action policy should be funded at a higher rate than those which do not.**

Studies indicate again and again that minority physicians are much more likely to serve minority patients. And a disproportionate share of the medically indigent are minority.

The number of minority U.S. medical students and residents is dropping. Thus, it is clearly in the best interests of the medical community - both ethically and fiscally - to support residency programs which have demonstrated a commitment to train minority physicians.

This Council has a unique opportunity to recommend that Congress provide funding priorities to residency programs comprised of doctors who serve the specialties, the hospitals and the communities with the patients of greatest need. On behalf of the National Federation of Housestaff Organizations, I encourage you to take that opportunity. Thank you.

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Testimony before
The Council on Graduate Medical Education

November 19, 1987

Submitted by Ruth S. Hanft

Introduction

I appreciate the opportunity to appear before the Council as an individual to present my personal views on a number of issues related to the supply, distribution, education, costs of education, graduate medical education and financing of this education for physicians.

As a long-time observer, researcher and commentator of the health professions education field, I see the following issues and problems as major ones.

- Concerns based on the GMENAC report that there is a surplus of physicians, which may not be the case;
- Continued maldistribution of physicians by specialty and geography;
- Decline in minority, particularly black, enrollment in medical schools, and barriers to attendance by low-income students;
- Dysfunction between education of physicians and societal need;
- Rate of increase in costs of medical education;
- Current financing of graduate medical education which undermines the goals of increasing the supply of primary care physicians and non-hospital training;
- The critical importance of graduate medical education financing in cross-subsidizing indigent care;
- Data issues and problems (described briefly in Appendix I).

There are other major issues that are important and interdigitate with the above, but which may be more appropriate to another forum. These include the missions of the academic health centers and the interplay of missions, curriculum, faculty role models, etc.

Supply

The GMENAC report based on data and projections from the late 1970s predicted a surplus of physicians. Many of the assumptions that underlie the initial estimates have changed. In addition, there is no precise methodology in any field to project manpower need. Let me just deal with some of the changes that have occurred and some of the unknowns.

Changes

Productivity is changing. The increase in HMO and salaried physicians changes productivity. Physicians in these settings work fewer hours and see fewer patients. The number of women in medicine is rising rapidly. Numerous studies show significant differences in women's practice styles, fewer patients and shorter careers. Two-earner professional families have also influenced productivity. There is also anecdotal evidence of earlier retirements of the current physician pool.

Demographics of the population: Projections of the size of the elderly population increase annually. The over-85 population is the fastest growing population group with substantially higher utilization rates than any other group. While it is possible that our ethical standards for keeping people alive when quality of life has ended will change, it is unlikely in the near term. In addition, as further breakthroughs in treatment and prevention of cardiovascular, cerebrovascular illness and cancer continue, the aging trends will accelerate. The baby boom population will reach their fifties within the next decade. As you are aware, chronic illness begins to increase rapidly when individuals reach their fifties. If the emerging improvements in prevention and treatment continue, all population projection trends will need to be altered.

Utilization: Recent Medicare data indicate a sharp increase in utilization of physician services and home health services. Part of this is due to the emphasis to shift services to out-of-hospital care and to reductions in length of stay, but part is a real increase in utilization, whether or not appropriate. Utilization will continue to increase as the baby boomers reach fifty, unless we begin serious technology assessment and utilization review. AIDS is an unknown potential. In cities with high incidence, AIDS has begun to swamp resources.

Technology: We simply do not know the future impact of technology developments on life span or utilization of services. If these developments are new vaccines, they may reduce future utilization. If midway technologies like artificial organs, they will increase utilization.

Financing: Financing clearly has an effect on utilization. There are 35 to 37 million people who are uninsured. Efforts are being made to extend coverage to these groups of people with unmet needs. We may well develop a universal private/public financing program in the 1990s. The effects of such a program are bound to increase utilization.

Other Unmet Needs: There are numerous functions and sites of care that are not adequately staffed by physicians. These include: mental hospitals, developmental disabilities facilities, prisons, public health clinics. There are numerous subgroups of the population that are not being reached, such as the homeless, teenaged pregnant women. If we are really serious about technology assessment and appropriateness review, these functions also require physician manpower. Well-trained clinical researchers with M.D. degrees continue to be in short supply.

In other fields with surplus, unemployment is notable. I know of no increase in unemployment among physicians nor precipitous drops in income. It may be a little harder to get started, harder to locate geographically or in first choice of practice setting, but there are no major economic dislocations. I am not advocating building supply to create unemployment, but I am urging caution in terms of reducing supply versus future anticipated needs.

It would be unfortunate if enrollment were cut deliberately now and we woke up in 2010 to find ourselves back in the position of the fifties and sixties. There will be some natural decline in enrollment due to the demographics of the population, but deliberate reductions are a different matter.

While I have been told that some institutions have not been able to recruit enough qualified applicants to fill their first-year classes, I am dubious. A number of institutions have in the past taken "so-called high risk students" with great success. It is also clear that a number of schools have not been "recruiting" students. I urge LCME and the medical education community to review their criteria for accreditation and admission to assure that barriers are not erected to limit access to people who will make fine community physicians in the future. In fact, some commentators believe that current selection processes contribute to the emphasis on specialty rather than primary care emphasis. Perhaps if some of the criteria were changed, more students qualified and interested in primary care could be recruited.

Maldistribution

There are still medically underserved areas of the country, particularly rural and inner city areas. Furthermore, data from a number of states indicate the rapid aging of the rural physician pool with little sign of replacement. In terms of primary care physicians, no matter how the counts are made, less than half of the physicians are primary care physicians, and less than half the physicians in residency programs are in primary care training. There is a clear mismatch between perceived needs and reality.

Part of the problem may be in the financial constraints of financing outpatient based primary care training in internal medicine, pediatrics and family medicine. Part may be the differential income potential between cognitive and procedure oriented specialties based on current UCR fee structures. In any case, the goal over the last fifteen years to increase primary care physicians is as far off as it was then.

There are a number of actions that can be taken to increase the balance of primary care physicians versus specialists. These include the following types of actions, some of which will be described in greater detail later.

- Further reduce Medicare direct payments for specialty training and increase them for primary care and place the saved funds in a pool for distribution for primary care and outpatient training;
- Charge tuition for all subspecialty training; with tuition possibly structured on a combination of need for the subspecialty and future income potential;
- Increase other direct grant support for primary care outpatient training in internal medicine, pediatrics and family medicine;
- Urge the RRCs to review requirements in medicine and pediatrics, e.g., does the length of the requirement for neonatal intensive care training in pediatrics make sense for community pediatrics;

- Stimulate the growth of the joint general medicine, general pediatrics programs;
- Restructure physician fees under Medicare and Medicaid to increase the relative values of time and cognitive services versus procedures.

Minorities and Low-Income Students

Whatever gains were achieved by the mid seventies in terms of enrollment and retention of minorities in medical school have steadily eroded. The latest data show that blacks constitute 6.1 percent of medical school enrollment including those repeating the first year and Hispanics 3.9 percent of enrollees. Five percent of the recent graduates were black, and 3.4 percent were Hispanics. There has been a growing disparity between acceptance rates of whites and blacks in the past several years. In 1986, 55 percent of all students who applied were accepted, but only 44 percent of blacks who applied were accepted, showing a shift in the acceptance proportions over time. While there are many complex reasons for the failure to increase minorities and blacks in particular, there are serious consequences in terms of service goals as well as equal education opportunity goals. Minority physicians are more likely to serve in underserved areas and to serve minority populations. There is a clear relationship between the availability of minority physicians and access to care.

Preliminary data show increasing difficulty for low- and lower-income students to attend medical school because of the rising costs of education and the decreasing availability of scholarships and loans. This is an increasingly serious problem in terms of equal educational opportunity, future specialty and geographic distribution of physicians. High debt levels of those who attend medical schools may influence selection of higher earning specialties and act as a further disincentive to entering primary care specialties and locating in less affluent inner city and rural areas. While tuition represents a very small proportion of medical school revenues it continues to rise and is substantially higher than tuition in many graduate fields. Added to undergraduate tuition which is also rising, without subsidized loans and scholarships it becomes a major barrier for lower or moderate income students.

There are a number of actions that could be taken to increase the pool of qualified minority students. All of them require active commitment and participation of the nation's medical schools. These include but are not limited to:

- Linkages between medical schools and "magnet high schools" with large minority enrollments;
- Assistance by the medical schools to the historically black colleges to improve science instruction and provide tutorials to promising students;
- Special remedial and advanced summer programs sponsored by the medical schools in high schools and colleges for minority students;
- Return to remedial programs and tutorials for students accepted to medical school but who have gaps in earlier education;
- Continuation of special support to minority health professions institutions.

Clearly the above require special funding.

There are other actions that require no new direct funding. These include:

- o Increase in NIH summer fellowships for minority college and medical students;
- o Renewed medical school efforts to recruit minority faculty and special programs (sabbaticals, NIH visiting scholars) to enhance skills;
- o Increase in medical school recruitment efforts to enroll minority students. I find it remarkable that a small number of schools have consistently maintained high minority enrollment while the majority of schools have records that can be regarded in many cases as abysmal.

Finally, student financing is critical. We must return to full scholarships for low-income students, and subsidized loans for lower middle income students.

Dysfunction between Education of Physicians and Societal Needs

Numerous commentators have commented on the dysfunction between the education of physicians and societal needs, not merely in terms of primary care and specialty distribution. The Association of American Medical Colleges (AAMC) has made recommendations, as have other groups. Major criticisms from my perspective include the following:

- The mixed missions of the institution and heavy emphasis on research and specialty patient care activities with the undergraduate student literally a byproduct of faculty effort. The number of "community medical schools" with a primary emphasis on undergraduate education and primary care remains a minority among the institutions, and some of these are attempting to emulate the more traditional model.
- Faculty role models that run counter to the model of community physicians. Academic rewards are based on research accomplishments and clinical specialization. General medicine, general pediatrics, and family medicine remain the stepchildren of academic medicine. The tenure, salary and other reward structures must change.

- The curriculum, while discussion may be appropriate to another forum, is criticized for rote learning rather than problem solving, lack of emphasis on humanities and behavioral science, technology oriented but with no technology assessment and failure to use computerized analysis and clinical data banks, short on primary care and geriatrics.
- Training sites which are focused in inhospital settings and tertiary care settings with emphasis on technology and subspecialties. The financing problem is key here.
- Too much reliance on residents for the teaching of undergraduate students.
- Steady lengthening of residency programs.

While I am not an expert in this area, my impression is that a new Flexner-type study of the whole continuum of medical education is long overdue.

Costs of Education

While the costs of M.D. education cannot be easily disaggregated from research and patient care, a number of studies have analyzed data and made estimates of these costs. There are striking cost differences among institutions for the "education functions," without any indication of differences in the quality of education. Two factors appear to influence costs, undoubtedly there are others. The first is class size. Schools under 100 students per class tend to have higher education costs, costs decline between 100-150 students, and decline further from 150-200. If enrollment cuts continue and accelerate, unit costs will rise, unless schools consolidate. The second factor is an educational faculty equivalent to student ratio. The higher the faculty to student ratio, the higher the cost. Which leads me to the issue of the exponential increase in faculty and the trend in faculty salaries.

Full-time faculty as reported in the most recent education issue of the Journal of the American Medical Association (JAMA) shows a decline in total enrollment of almost 1,000 medical students between 1985 and 1987, with an increase in full-time faculty of 5,000. Full-time faculty now exceeds the number of medical students. I am not naive enough to assume that the majority of time is devoted to the M.D. student. It is clear that a minority of time is, in fact, probably the smallest proportion of faculty time. However, this steady and increasing faculty size raises numerous questions as to efficiency and cost effectiveness of the education.

The schools must begin to pay attention to these issues.

Faculty salaries have also been rising steadily. Salaries and fringe benefits in many cases now make faculty positions as competitive, if not more so, than community practice in many areas. The whole issue of practice plan organization and dispersal of funds needs to be reviewed in terms of institutional goals.

Regarding the costs of graduate medical education, an even more difficult subject, numerous studies have attempted to grapple with the issue. It is clear from most of the studies that a very large proportion of residents' time is spent in, or contributes to, patient care. In addition, time is spent teaching undergraduate medical students, more junior residents. Who benefits from graduate medical education?

- Patients, particularly indigent patients, who may receive care they might otherwise not receive;
- The hospital which can maintain 24-hour backup for sophisticated services, provide outpatient and emergency services, and which perceives the advantages of graduate medical education in terms of quality of care;
- The teaching physician who has coverage for his/her patients and, sad to say, frequently bills full fees for services provided predominantly by the resident. Faculty also receive payment for supervision. The double payment problem is still with us.
- The medical school, which gets free junior faculty for instruction of third- and fourth-year students; and much of its support for clinical education through faculty salary support;
- The resident who receives specialty training enhancing future earnings potential and now also receives a living wage.

Financing of Graduate Medical Education

As you are aware, the financing of graduate medical education is mainly through third-party payments for patient care that is hospital based. Until about 1967, shortly after the advent of Medicare and Medicaid, resident salaries were small stipends, and a large proportion of faculty were volunteer faculty. The initial decision of Medicare (and hence Medicaid) to pay resident salaries and fringe benefits, and for supervision of faculty under Part A and to allow teaching physicians to bill for personal and identifiable services under Part B, changed the dynamics of support for both graduate and undergraduate medical education.

As you all are aware, graduate medical education has grown in size and in length. Resident salaries rose rapidly until the early 1980s, and patient care funds to support the enterprise have grown rapidly.

Recent Medicare changes will slow the growth. Medicaid, now separated from Medicare in many states, no longer pays for graduate medical education in the same manner as Medicare. In addition, competitive pressures and discounting threaten the flow of funds from private third parties.

Studies of the costs of graduate medical education and the cost differences between teaching and non-teaching hospitals are inconclusive as to the burden versus benefits of graduate medical education. The Anderson Lave study for Commonwealth, for example, shows that the difference in costs between non-teaching and major teaching hospitals is only in part attributable to graduate medical education and includes such items as severity, ambulatory care, patient mix, higher wage levels.

Most studies have focused on hospital studies and do not include a tracing of physician and other costs of care.

In discussing graduate medical education specialty distribution, other distributional issues and appropriateness of education, the hospital orientation and the financing of graduate medical education become problematic. Hospitals are treating more critically ill patients. Primary care physicians are regarded as the core physicians to serve the majority of future patient care needs. Outpatient training in community practice, HMOs, experience with nursing home patients in long-term care, care of the elderly, the chronically ill is critical to the training of appropriate future physicians. The current financing methods are a major impediment to the development and maintenance of appropriate training sites and opportunities as well as to increasing the proportion of physicians trained in primary care.

Furthermore, current financing through hospital payment places heavier financial burdens on certain regions of the country with some regions subsidizing the training of physicians for other regions. This is due to a historic anomaly of where medical schools and teaching hospitals developed and the shifting of the population in recent years to the sun belt, leaving the rust belt and east coast with an even more disproportionate graduate medical education burden.

My suggestion to the Council is that they consider a number of alternatives to the current financing system, some of which are not mutually exclusive. These include:

- The changes in Medicare payment suggested earlier;
- A revenue tax on all third-party financing including self-insured plans, Medicare and Medicaid, placed in a pooled fund to underwrite all sites of training;
- Contribution by the medical schools of 10 - 15 percent of resident salaries where residents teach undergraduate students;
- The development of the IOM recommended unified plan for the support of residents and faculty (modified Mayo plan);

- Cost-based hospital reimbursement for both faculty and residents and no faculty billing for teaching patients in certain hospitals with large indigent loads;
- Tuition charges for residents in subspecialty training.

Patient care funds should continue to support the proportion of activities that actually provide patient care. It is the distribution of these funds that require change.

Graduate Medical Education and Indigent Care

A number of studies have shown that teaching hospitals as a class provide more uncompensated care than non-teaching hospitals. However, as Congress has recognized in establishing disproportionate share payments, only a subset of teaching hospitals provide large amounts of uncompensated care, mainly public general hospitals and certain inner city and state university hospitals.

There is a long-standing symbiosis between graduate medical education and indigent care. I need not remind this audience of the linkages between medical schools, undergraduate and graduate programs and hospitals, such as Parkland, Grady, Charity, L. A. County system, N. Y. Health and Hospitals Corporation hospitals, etc., that serve a high proportion of indigents. While in the best of all worlds, indigent care would disappear and everyone would have basic coverage and graduate medical education could be separated as an issue, this is not the case. I made a rough calculation from COTH data by ownership of hospital. Approximately half of these COTH residencies are located in public hospitals with 18 percent in under 40 county and municipal hospitals, 19 percent in approximately 40 state university hospitals, and approximately 13 percent in Federal hospitals. Approximately 150 public COTH institutions support half the residencies, in contrast to 250 private institutions that support the other half.

Great care must be exercised when shifting the source of payment and sites of training for graduate medical education so that reductions are not made in the contribution of graduate medical education to indigent care. In the ideal world, each function would stand on its own with appropriate funding. We don't have an ideal world.

- Disproportionate share Medicare payments should continue.
- Medicare/Medicaid should continue to support Part A graduate medical education payments for at least the patient care time of house staff.

Appendix I

Data Issues and Problems

Federal data collection support has declined over the last several years. In health personnel data, for a variety of reasons the Department of Health and Human Services (DHHS) has not collected original data; rather it has relied on professional associations for these data.

The data that are important for policy considerations of the Council's charges are widely scattered as to source and are frequently incomplete or conflicting.

Incomplete data include:

Practice patterns of physicians and productivity. AMA surveys provide some data but not adequate for productivity analysis.

Graduate medical education and teaching hospitals.

While there are some detailed data for the COTH hospitals, similar detail does not exist for the 600-800 non-COTH teaching hospitals. There are inadequate data on out-of-hospital training programs.

Conflicting data:

Residency counts vary among COTH, the Directory of Residency Training and the Medicare cost reports.

The categorization of teaching hospitals varies. In the Wisconsin study, five hospitals reported as teaching hospitals by one source or another, did not have approved ACGME or AOA programs.

Lack of a Clearinghouse

Anyone wishing to conduct health manpower research must rely on multiple data sources, including AMA, AOA, NIRMP, Medicare Cost Reports, COTH, Bureau of Health Professions, etc. Many of these data are proprietary presenting some access problems. More important because the data are collected by many different sources and much of the data are proprietary, the quality of the data and sometimes the methodology of collection are uncertain. There is no central clearinghouse.

GRADUATE MEDICAL EDUCATION: A LOST CAUSE OR A HOPE FOR THE FUTURE?

(A RATIONALE FOR LINKING FEDERAL FUNDING TO EDUCATIONAL POLICY)

Martha S. Gerrity, M.D.
November 19,1987

I am here today, not as a representative from an organization, but as a physician actively involved in the education of residents and medical students. Even in my short career as a physician, and shorter career as an educator of physicians, I have become concerned by disturbing trends in physicians, their attitudes towards patients and medical education. I hope to impress upon you this same concern and caring. In addition, I will offer you ideas for approaching these problems - ideas of hope that we will refocus our attention on quality and what that truly means in medical education and health care.

My task today will be accomplished in 3 steps. First, I will provide you with my "grassroots" perspective of the trends in patient-physician relationships and graduate medical education. Second, I will outline a rationale for continuing federal funding of graduate medical education, but within a framework that will 1) link policy to financing and 2) facilitate change in the medical education system. Finally, I will offer specific suggestions for a broad-based review of the structure and content of medical education.

"GRASSROOTS" PERSPECTIVE

What do I see from my "grassroots" perspective? I see an advesarial tone developing between patients and physicians. Just 2 weeks ago, I looked at a local free paper and found this article,

"Does Your Doctor Dislike You?"

"Many physicians dislike patients who won't comply with their instructions or who ask too many questions.' And many dislike treating obesity, alcoholism, low back pain and inoperable cancer."

More and more, I see in the lay and medical press complaints that physicians do not listen, communicate clearly, understand or even spend enough time with their patients. This is not surprising from my viewpoint! Our current health care system has few incentives (except dedication) and many disincentives (especially financial) to do these activities.

How can I teach these caring behaviors to residents when I know there are few incentives for me to do them in my own practice? Added upon this is a second layer of disincentives from the academic system. I am hired, salaried and rewarded for my patient care income and research output. Oh yes, I am also supposed to teach. But, I will not be trained to teach or helped to improve or even be rewarded for the extra hours I work because I want to do a better job teaching. Frankly, I am amazed that attending physicians make any attempt to teach. To go beyond teaching facts and to teach humanism and caring takes even more time - time to model behaviors, to observe resident-patient interactions and then to skillfully give feedback.

What distresses me even more is the growing intensity of negative emotions among residents - anger, frustration, and a sense of having no control over anything. These emotions spill over into patient care. Patients not only become diseases but receive derogatory labels. Residents get "hit" or "hurt" when a patient is admitted to their ward. Some of the first year residents at one of our most prestigious medical centers have taken to saying, "I am stool. Stool doesn't question." Something is terribly wrong with a system that produces these emotions and behaviors in intelligent individuals who went to medical school because they "liked working with people."

Many have called for changes in medical education for these and other reasons, but our system is recalcitrant. It is recalcitrant because it is fragmented. There are approximately 115 university hospitals and 900 non-university hopitals receiving Medicare funds for medical education. Among these one thousand hospitals, there is wide variation in resources, needs and institutional traditions. More importantly, medical education is recalcitrant because the institutions, and individuals within the institutions, work competitively and not collaboratively. I am not saying that competition at any level is bad. I am saying competition at our current level produces absurdities such as arguments over who found the AIDS virus first or falsification of research data.

A RATIONALE FOR FEDERAL FUNDING OF GME

We have just advanced to my second step - outlining a rationale for federal financing of graduate medical education. I will begin by restating the first of 5 points in my rationale. Medical education is a fragmented, internally competitive system recalcitrant to change without an external framework and a lever.

Second, the education of physicians, along with health care, is a collective or common good. A collective good is a good whose provision or consumption is shared by the members of the community. The Council on Graduate Medical Education's first principle states, "the primary concern of the Council must be the health of the American people. There must be assured access for all to quality health care." If we accept this principle, that health care is not only a private good but also a collective good for the

American people, then we must view medical education as a collective good. Physicians play a pivotal role in health care delivery, and for many Americans they are still viewed as authorities both locally and nationally. Therefore, we must assure that they are trained adequately and have the nation's health care interests in mind.

Third, Medicaid, provider liscensure and health planning under P.L. 93-641 taught us an important lesson. These programs failed to acheive their goals because their funding was not linked to the responsibility for their administration and regulation. One level of government (the federal level) funded these programs while another level (the states) attempted to administer and regulate them. The results were dismal primarily because those who regulate the program have no financial incentives to make it work. (I refer you to the article by Bruce Vladek for the details about these programs and their failures.)

Fourth, the federal government is our best lever for implementing national policy. The old adage, "he who pays the piper calls the tunes," can be applied here. In the United States, the only payer with a nation-wide perspective and the mandate of the American people is the federal government.

Fifth, for the relatively small cost of financing GME, estimated to be 1-2% of total health care costs in the United States, we can create a framework to make nation-wide changes in medical education. These changes may prove to be the solutions for our most serious health care problems. For example, incentives could be created for residency programs to staff indigent care facilities as part of an ambulatory care requirement.

In summary, my five point rationale for the federal funding of GME is

1. Medical education is a fragmented, internally competitive system recalcitrant to change.

2. Medical education is a collective good whose provision and consumption is shared by the members of our community, the United States.

3. A framework that funds at one level but places the responsibility for administrating and regulating a program at another level will fail.

4. Our only system for implementing national policy and making nation-wide change is the federal government.

5. For a relatively small cost, compared to the total cost of health care in the U. S., we may find a key that will unlock solutions to the larger, more expensive problems facing our health care system.

I suggest we move towards a federal framework in the following manner.

First, calculate the amount of money currently given to each teaching hospital - include Medicare's direct and indirect payments for medical education.

Second, maintain this level of funding for 2-3 years, but award it to each institution as a grant earmarked for medical education.

Third, require every institution, each year, to account for how it spent the money. This accounting process will begin to disentangle "teaching costs" from patient care costs.

Fourth, go back to those who do the teaching and the learning and ask them, "do these teaching costs make sense, and if not, why not?"

Fifth, during this 2-3 year "phase in" period implement the broad-based review of medical education, as suggested by the Subcommittee on Graduate Medical Education Programs and Financing.

Sixth, now use this framework to set specific criteria for receiving a grant. Base the criteria on the recommendations from your review of medical education, the accounting information gathered from teaching hospitals and national health manpower needs.

Needless to say, this framework will not be exactly what we want the first time around. It should evolve and improve as we learn; therefore, mechanisms for its evaluation and revision should be built in at several stages.

SUGGESTIONS FOR THE BROAD-BASED REVIEW OF MEDICAL EDUCATION

I have completed the first two steps of my task today. The final step will be 3 brief suggestions for the recommended, broad-based review of the structure and content of medical education.

My first suggestion - Examine the traditions, structure and financing of academic medical centers. It is within this structure that medical education resides.

Second - Approach the Robert Wood Johnson Foundation and ask them to use the National Meeting of the Clinical Scholars Program as a "think tank" for addressing the problems of medical education. This would supplement your review by giving you access to over 50 physicians selected for their innovative thinking and their desire to bring knowledge and skills from non-biomedical fields into the medical care arena.

Finally - Include people who are developing new methods for education or new ways of looking at health care. Call upon people like David Sackett, Dan Beauchamp, Kelley Skeff, Donald Schon, Howard Barrows and Alan.Detskey.

In conclusion, I shared with you my perspective of medical education, outlined a 5 point rationale for federal funding of GME and offered 3 ideas for a broad-based review of medical education. Dr. Samuel Martin, III, in a recent editorial, urges us to lay down our arms and work collaboratively to shape the future and direct trends in our health care system. I can think of no better place to start than with medical education.

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Title: Testimony of the Association of Professors of Medicine
before the Council on Graduate Medical Education

November 19, 1987

I am Harold J. Fallon, President of the Association of Professors of Medicine. The membership of the Association consists of the chairpersons of the 127 University Departments of Internal Medicine in the United States. The mission of the APM is to enhance the education of physicians in Internal Medicine, related specialties, and in biomedical research. The APM is the current host of the Federated Council on Internal Medicine. Participating societies in the Federated Council include the American College of Physicians, the American Society for Internal Medicine, the Association of Program Directors in Internal Medicine, the American Board of Internal Medicine, and the Association of Professors of Medicine. Each of these societies is deeply concerned with the appropriate supply of internists and witn the level and quality of graduate medical education in the specialty. Recently, the Federated Council sponsored a preliminary reassessment of manpower requirements in Internal Medicine. Time constraints required that the review be based on previous data, however major new factors affecting physician demand were considered in the analysis. The latter have significant impact on earlier projections. The final report from this study should be available soon and copies will be submitted to the Council at that time. In addition, the APM and other organizations in the Federated Council will sponsor an extensive reappraisal of the curriculum for residency training in Internal Medicine. The Professors of Medicine believe that both of these efforts will enhance the quality and efficiency of graduate medical education in Internal Medicine.

Profound changes in health care delivery in the United States, especially in the field of Internal Medicine, require an extensive reassessment of manpower needs. For Internal Medicine major factors in the reassessment should include:

1. The changing clinical demands in the practice of Internal Medicine. Technological advances in areas such as cardiology and gastroenterology have resulted in new procedures; for example, angioplasty and colonoscopic polypectomy, which have both decreased the need for surgical intervention and increased the demand for technically skilled internists. Simultaneously, the shift of clinical practice from hospital to ambulatory facility has accelerated demands for general internists and those specialists involved with ambulatory care. Managed health care systems require physicians skilled in preventive medicine and patient counseling as well as general adult medical care.

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2. The increasing age of the American population has raised requirements for physician services in virtually all aspects of Internal Medicine. Similarly, the advent of AIDS has had a substantial impact on general internists and subspecialists in infectious diseases and oncology, in those areas where the disease is commonplace. Increased demand is predicted if the disease spreads nationally.

3. Changing lifestyle expectation of young physicians will affect the productivity of internists. Most surveys suggest that medical students, housestaff, and young physicians expect more leisure time to devote to family, cultural or athletic activities than in the past. Assessment of manpower needs based on assumptions of more than a sixty hour work week may be invalid. About one-third of residents in Internal Medicine now are women and the trend is upward. Estimates indicate that women devote 10 - 40 percent fewer lifetime hours to the practice of medicine than men.

4. As many as 30 percent of Americans may have inadequate medical insurance. Often the uninsured do not receive regular medical care except in times of crisis and at the end stage of their disease. If provision of medical care to less fortunate Americans becomes national policy, the demand for general and specialty Internal Medicine services would increase.

5. Each of the preceding factors has tended to enhance the demand for internist services. However, there is evidence that the supply may be decreasing.

   The interest of U.S. medical students in careers in Internal Medicine declined last year. There is some evidence for a decrease in quality as well. Last year, 350 fewer U.S. medical graduates entered categorical training programs in Internal Medicine. The number of USMG's in these programs fell to 64 percent, an all time low. Historically, over 25 percent of all residents in training in the United States complete programs in Internal Medicine. This is appropriate since internists provide the majority of general and specialized care to adults of all ages. Thus a trend away from Internal Medicine in favor of more highly technical and subspecialty-oriented disciplines runs counter to most assessments of health care needs in this country.

The Association of Professors of Medicine concludes that a significant shortfall in highly qualified internists could be manifest in the future. We believe that the quality of the American health care system depends upon a continued supply of well trained internists and subspecialists. Efforts to improve the attractiveness of Internal Medicine by changes in training programs and in practice are underway.

The Association of Professors of Medicine wishes to make several specific recommendations to the Council. These include:

1. Establishment of a permanent mechanism to assess graduate medical education requirements in the U.S. The effort should be adequately funded to conduct extensive and accurate assessments of current national physician manpower needs and to project future needs based on the impact of recent changes in health care requirements.

2. Support for graduate medical education should be fiscally sound, and all private and public parties should participate. All U.S. medical graduates should expect access to adequately financed graduate medical education. This commitment is essential if we are to attract an increased number of talented, poor, and minority students into medical careers. Incentives could be established to encourage young physicians into fields such as General Internal Medicine and Geriatrics where shortages seem likely.

3. The Association of Professors of Medicine does not favor continued financial support for the graduate medical education of all interested foreign medical graduates. A select number of such trainees who plan to return to their native land should be supported. However, the widespread use of foreign medical graduate trainees as low cost substitutes for experienced physicians and paramedical personnel cannot be condoned.

Supplement to Testimony of Association of Professors of Medicine to Council on Graduate Medical Education

November 19, 1987

In addition to these specific recommendations, the Association of Professors of Medicine would like to comment on three aspects of the draft proposals currently before the Council on Graduate Medical Education.

1. The Association of Professors of Medicine generally support the conclusions and recommendations of the subcommittee on physician manpower. However, we do not believe there is sufficient data to indicate with certainty that an aggregate oversupply of physicians in the United States will occur in the foreseeable future. It seems prudent to recommend that earlier projections suggesting an aggregate oversupply require careful reassessment at this time.

   On page two of the physician manpower draft, it is stated that there is an undersupply of physicians in family practice and an adequate supply of physicians in general internal medicine. The boundaries of the practice of family medicine and general internal medicine are rapidly merging because of the inability of family physicians in many areas to practice minor surgery, obstetrics and neonatology. The major differences between family physicians and general internists at present are related to educational curriculum and an emphasis on pediatrics in family medicine programs. It is anticipated that current practice realities will lead to changes in the curriculum for both general internal medicine and family medicine in the near future. We recommend the following statement on this topic. "Current information suggests that there may be an undersupply of physicians providing general adult medical care in the fields of Family Medicine and Internal Medicine."

2. The subcommittee on financing graduate medical education criticizes efforts to increase the length of residency training. Training requirements are determined by the independent specialty boards in response to perceived educational needs for physicians in current practice. Residency Review Committees must concur and determine individual curriculum requirements. Finally, approval by the ACGME is necessary. This multi-faceted mechanism should ensure prudent adjustment of time requirements and has worked well in most fields. Recently, the American Board of Internal Medicine has proposed an extension of cardiology training based on the dramatic increase in procedural and technical skills expected of modern cardiologists. The increase in residency training is justified by a desire to ensure excellence in board certified cardiologists. Issues relating to manpower supply or cost should not receive priority in such decisions.

3. The recommendations of the subcommittee on foreign medical graduates support the concept of training foreign graduates planning return to their native lands. The Association of Professors of Medicine agrees with this position but does not believe that graduate medical education in the United States has an obligation to train all qualified foreign-born medical graduates who may wish to enter the United States to practice. There is no acute overall shortage of physicians to justify this policy. Moreover, other nations do not provide unlimited access to practice by foreign physicians.

U. S. graduates of foreign medical schools should undergo rigorous examination similar to those of U.S. medical schools before entering graduate medical education in the U.S. The Association of Professors of Medicine agrees with the subcommittee that abrupt changes in the current system are undesirable. Furthermore, alternative means of provision of medical services to the medically indigent must be developed in hospitals that depend on foreign medical graduate trainees for these services.

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Testimony by Association of Program Directors in Internal Medicine before COGME, November 19, 1987

I am Dr. Eleanor Wallace, President of the Association of Program Directors in Internal Medicine, a 10 year old organization representing 95% of the more than 440 residency programs in internal medicine.

Those 440 programs are extraordinarily diverse. They range from large tertiary care university and university affiliated programs to small community hospitals. Some serve large indigent populations. Some are highly FMG dependent. They are both urban and rural. Both the societal needs served and the training emphasis in our constituent programs vary markedly according to their perceived missions, size and geographical location.

APDIM came into being after the major thrusts of the 1950's and 60's to program expansion and subspecialization had occurred. Reviewing the twice yearly programs which we have offered our membership, all the problems with which we are struggling today have been identified and presented for discussion over these last years.

We have recognized for some time that changes in our programs were needed to deal with a growing mismatch between the inpatient experience and the reality of internal medicine practice. APDIM has strived to offer its membership examples of programs which have successfully incorporated those elements which we have labelled as "primary care/ambulatory training" focused.

The diverse nature of our training programs is an obstacle to simple solutions. What could be done in small well supported programs, or with Federal Grants in large academic medical centers, could not be generalized to the bulk of internal medicine residencies.

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Programs had become dependent on residents for service. Inpatient demands, in many sites, had become increasingly acute and the resources (sites, faculty and funding) needed to develop educationally valid ambulatory settings did not exist. Federal and third party GME funding mitigated against shifting trainees into ambulatory sites. Cost containment efforts deterred hospital administrators from funding alternate health care deliverers to free up residents.

APDIM recognized the need for a data base which would tell us more precisely what our training programs were doing, so that the scope of needed change could be determined. In the course of such a study it was hoped that programs which had developed innovative approaches would be identified. In 1985 APDIM undertook a survey of its training programs to develop such a data base. 317 of 442 programs responded. With support from HRSA, the survey was extensively analyzed with particular emphasis on aspects relevant to ambulatory/primary care training. Sites for such training, time spent, supervision and funding were explored. The presence in standard internal medicine residencies of the components of primary care training, as defined in the literature or by the title VII grant requirements, were evaluated. The impact of a coexisting primary care track on the contents of the standard track were examined.

The completed study has been forwarded to Dr. Clare, the project director for HRSA and will I assume, be made available to you in full.

The results can be readily summarized and highlight the extent of change which would be needed to move training into a more primary care/ambulatory oriented training mode:

1) the majority of residents in internal medicine training are receiving inpatient, subspecialty focused training

2) ambulatory training remains, for the majority, a one-half day a week experience in hospital clinics

3) relatively few programs offer an array of primary care related rotations (psychosocial skills, office ENT, orthopedics, preventive medicine, etc) and fewer residents select these options over the standard subspecialty rotations

4) only about one half of programs state that they have formal guidelines for ambulatory training for residents in the standard track

5) evaluation of residents in ambulatory settings has for the most part not yet focused on primary care skills

6) Funding for ambulatory experiences, particularly those outside of the hospital, is scanty and unsatisfactory.

The survey revealed a small use of managed care systems for teaching (40 programs utilized an HMO for a small number of their trainees). A larger number used private offices; there were sizeable geographical differences in such usage.

The presence of a primary care track in the same institution did not appear to influence the behavior of residents in the standard track with regard to choice of electives (primary care versus medical subspecialties) or career choice after completion of training. This probably reflects the location of most of the primary care tracks in large academic medical centers, with self-selection of residents into these options at the onset of their training and little crossover.

As part of FCIM, (the Federated Council for Internal Medicine) we are looking at the need for change in residency training. We are not certain that the manpower estimates have yet determined the future needs for general internists and subspecialists appropriately. We do believe however that it is time to restructure internal medicine residencies.
The decision as to how much such training should be shifted to primary care emphasis should be made thoughtfully and by a consensus of program directors, of those representing internists in practice, and of the accrediting bodies. The availability of appropriate outpatient sites and supervision in those sites needs to be determined and may serve as a limiting factor. Development of flexible curricula and guidelines for training must be part of this process of transformation so that internal medicine training can meet diverse needs to provide society with generalists and subspecialists.

Funding for these changes must address not only the needs at ambulatory sites but the issue of inpatient care. Movement of residents off the hospital floors for increasing amounts of training cannot be done without a clear policy about who will care for their inpatients. This problem will be most acute in city, county and VA hospitals where service to the indigent and education are inextricably linked. Even in the voluntary sector, it is likely that other health care providers will be needed as teaching services lose housestaff.

APDIM agrees that changes in internal medicine residency must be made. These must be done in a careful, organized approach with attention to content, resources, a plan for funding and a timetable for change which does not jeopardize a system which has served medicine well. The internist as generalist and as subspecialist has, will and should continue to be the basis for enlightened medical care delivery in this country.

Our most concrete suggestions are that we need:

1. better data on need for primary care internists and subspecialists

2. better data on availability of resources needed to transform training as needed (training sites and supervisory faculty)

3. establishment of the cost of moving training into ambulatory sites, of providing alternate health care deliverers for inpatients, and of providing the faculty teaching and supervision necessary for ambulatory teaching

4. a source for such funding

5. establishment and funding of a task force for redesigning guidelines and curriculum for internal medicine residency training

-and-

6. a timetable for evaluation of all of the above to be followed by a program for implementation.

A NEW METHOD OF FINANCING GME WHICH ELIMINATES COST SHIFTING

The Association of Hospital Medical Education (AHME) was founded in 1956 as a national, non-profit professional organization for the purpose of improving health care through medical education. AHME has approximately 270 community teaching hospitals as institutional members and approximately 550 individual members representing those institutions. AHME serves as a forum for the exchange of ideas and positions on national policy concerning the problems of graduate and continuing medical education in community hospitals. It is an active and working organization holding regular national and regional meetings, seminars and workshops regarding all aspects of medical education.

Since the advent of Medicare cost reporting in 1967 and the Tax Equity and Fiscal Responsibility Act (T.E.F.R.A.) in 1982, graduate medical education reimbursement has been divided into three parts. The first part has been the direct expense of graduate medical education which is limited to the stipends and/or salaries of the residents in training. The second part is the indirect expense of medical education that is relative to faculty salaries, depreciation, dietary expense, employee benefit expense, secretarial costs, administrative and general expenses, etc. The third part was the indirect medical education adjustment introduced by T.E.F.R.A. in 1982 but became a reality under the Prospective Payment System (P.P.S.). The indirect medical education adjustment was instituted by PPS to adequately reimburse teaching hospitals versus non-teaching hospitals for the severity of illness which is higher in teaching hospitals.

My discussion will reflect primarily on the indirect expense of graduate medical education which, as stated above, reflects overhead expense. Direct and indirect expenses are a pass through under the Medicare reimbursement program and not an expense which is paid within the Diagnostic Related Group (D.R.G.) payment.

Cost shifting has been a means by which hospitals have made the best use of third party reimbursement funds since the advent of Medicare in 1967. Since the introduction of the pass through by P.P.S. for graduate medical education direct and indirect expenses, cost shifting has been the byword especially for the indirect expense portion of graduate medical education costs.

In the Arthur Young Study, there is clear evidence that the cost of a resident in different institutions has a dramatic range. In southeastern Michigan, for example, a study of the Medicare cost reports reflects a cost range of $44,000 per resident to as high as $116,000 per resident. The difference in that cost is primarily reflected in the indirect expense or overhead portion. It varies from institution to institution because the indirect expense is determined by a step-down formula which develops a ratio between the total cost of a particular expense and the cost of the direct expense of medical education. Therefore, if a hospital's dietary expense is very expensive or if the depreciation costs are high, it is reflected in the indirect expense of the step-down formula.

It is my contention that the indirect expense step down formula provides a cost-shifting mechanism which can be avoided by developing a fixed percentage of cost to be added to the direct expense of salaries/stipends to reflect a more equitable manner of the financing of graduate medical education. For example, if a resident's salary in southeastern Michigan is $25,000, and a fixed percentage of 150% is utilized as the indirect expense, then the total reimbursement would be $62,500, [$25,000 (resident stipend) plus $37,500 (indirect expense determined by the 150% fixed percentage of the resident stipend)]. Using this formula would then allow for regional salary or stipend considerations and yet still provide a base for the indirect expense which would be fixed at 150%.

The increase of costs relative to graduate medical education can be addressed by using the Consumer Price Index (C.P.I.) as a limitation on cost increases. However, within the rules and regulations, an increase over and above the CPI would not be allowed unless a formal waiver was sought. The formal waiver would permit an increase in costs over the CPI. The rules and regulations regarding a formal waiver would spell out the conditions that would permit the filing of a waiver request. (An example of an approved waiver might be the inclusion of malpractice costs for the house staff which may cause a rise in graduate medical education costs well above the CPI.

Further, an increase in graduate medical education costs over the CPI would not be denied one year and then included in the base the second year. The base established by the institution's graduate medical education program expenses of Fiscal 1987 would be the base carried forward and adjusted only by the CPI

The average cost per resident should not vary dramatically, even in the large and small teaching hospitals/institutions. The Accreditation Council on Graduate Medical Education (ACGME) has general requirements for hospitals/institutions providing graduate medical education. The 23 Residency Review Committees of ACGME have special requirements for each specialty. Although these criteria are the same for all programs, the Arthur Young study indicates a dramatic difference in cost for residents. The reason for this difference is in the indirect costs/overhead. The step down formula accounts for this variability. It encourages cost shifting that will improve reimbursement. A fixed percentage for indirect expense would be equitable for all institutions and could eliminate the temptation to shift costs.

The fixed percentage concept proposed recognizes that the current method of computing indirect expense utilizes a step-down formula. Further, it also recognizes that direct expenses include costs other than resident stipends. The proposed concept of a fixed percentage would eliminate all other costs other than the resident stipend. The anticipated rules and regulations to be written by the Department of Health and Human Services, Health Care Financing Administration (HFCA), for the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (PUB.L. 99-272) may alter the method of determining indirect expenses. However, the proposed fixed percentage concept of 150% times the resident stipend will significantly simplify the process and eliminate cost shifting which has artificially increased the cost of graduate medical education.

THE SOLUTION TO STOP COST SHIFTING IS TO INITIATE A FIXED PERCENTAGE FOR THE INDIRECT EXPENSE.

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INTRODUCTION

Mr. Chairman, I am Alexander H. Williams, senior vice-president of the American Hospital Association. I am here today before the Council on Graduate Medical Education (COGME) to represent the Association and its 5400 hospital and over 40,000 individual members. It is my intention to provide specific comments on the preliminary recommendations reached by the Council, but before that I would like to make a few introductory remarks.

The issues surrounding graduate medical education are far reaching. The public policy on graduate medical education which is shaped today will have enormous impact on all health care delivery in the U.S., not just on institutions with university affiliated graduate medical education programs. You should know that in the United States currently, there are 961 hospitals with approved residency training programs which are not eligible for membership in the Council on Teaching Hospitals (COTH) of the Association of American Medical Colleges because they have less than four approved residency programs. These institutions nontheless have a deep interest and involvement in the matters under discussion and are represented by the AHA.

The American Hospital Association does not consider the proliferation of foreign medical graduates as an acceptable methodology for insuring adequate medical manpower for underserved areas. Nonetheless, we recognize that many innercity teaching hospitals which provide the bulk of health services to their surrounding communities are largely dependent on foreign medical graduates to provide that care. The AHA therefore urges caution in changing public policy on FMGs which might negatively affect the needed services provided by those institutions.

Because graduate medical education, medical practice and the provision of medical services are closely intertwined, decisions on the financing of medical education have far reaching implications for the number and specialty distribution of physicians and patient care, particularly referral services. Decisions to change the current financing system as well as the size, duration, content and quality of medical education programs should therefore be made cautiously and incrementally. The American Hospital Association further believes that funding for graduate medical education should continue through the patient care dollar until a workable alternative can be demonstrated to adequately support residency training and its related service activities.

COGME Preliminary Recommendations

A. Physician Manpower

In the interest of time, I will not comment on the physician manpower recommendations except to indicate our concurrence with the preliminary conclusion that there is a geographic maldistribution of physicians with too few primary care physicians in many rural and inner city areas. We also endorse the recommendation that incentives to encourage physicians to locate and remain in shortage areas should be continued and strengthened.

B. Foreign Medical Graduates

Under special contract to the Council, the American Hospital Association is currently undertaking a study to determine the specific connection, if any, between foreign medical graduates in training programs and the provision of medical care to the indigent. Our present policy on this matter reflects our belief that there may well be a connection. We therefore believe that any restrictions instituted by Medicare for the graduate medical education of FMGs should be phased in to avoid potentially negative effects on the delivery of care. We are pleased that this is also the Council's recommendation. We also applaud the supporting recommendation that greater financial resources are needed for provision of medical care to the indigent, particularly in those states with a recognized high dependency on training programs for provision of care to the indigent.

AHA agrees with the preliminary conclusion that no person, including a graduate of a U.S. medical school, has an absolute right or entitlement to a residency position. Through its involvement in activities of the Educational Commission for Foreign Medical Graduates, AHA subscribes to the principle of access dictated by individual qualifications rather than institutional qualifications or nationality. The American Hospital Association has been a consistent supporter of the provision of specialty training for international exchange visitors and is an early supporter and incorporator of the International Medical Scholars Program.

The American Hospital Association supports the addition into the ECFMG certification process of a clinical skills assessment and a test for spoken English. Pilot programs have shown that the clinical skills assessment screens out approximately 25 percent of the foreign medical graduates who would otherwise be eligible for ECFMG certification. There is significant anecdotal evidence that inability to communicate in English inhibits the educational process and creates a significant patient care problem.

The American Hospital Association opposes a program of formal recognition of foreign medical schools. We concur that it would be both presumptuous and unwise for the United States to attempt to provide recognition or accreditation of medical education programs outside its own domain. Furthermore, we believe that the present system of ECFMG certification is an appropriate screen of foreign medical graduates and adequately serves the purpose of protecting the American public.

C. Financing Graduate Medical Education

The American Hospital Association strongly supports the first two preliminary recommendations on graduate medical education financing. We concur that changes in the financing of graduate medical education should be undertaken in an evolutionary rather than precipitous manner and that payments for the direct costs of graduate medical education should be continued through existing mechanisms, utilizing current sources, conduits and recipients. We concur that there is not an immediate crisis and that immediate change is not necessary.

The American Hospital Association believes that the current practice of integrating the financing of graduate medical education into the payment structure for service provision is appropriate. We further believe that extensive reliance on private practice plans as a workable alternative for the financing of graduate medical education is unrealistic, except in a few institutions. The American Hospital Association is not opposed to the exploration of alternative sources and methods of financing for graduate medical education, but believes that any new method will, perforce, be strongly reliant on multiple sources of public funding.

AHA suggests the following principles for consideration by the Council in its continuing discussions on graduate medical education financing:

1. Society has an obligation to adequately fund residency training so that only well-trained practitioners practice medicine independently.

2. As any other payer, Medicare should contribute its proportionate share of the costs of graduate medical education.

3. Medicare should recognize that at least some of the costs associated with graduate medical education cannot be identified.

4. Medicare payment policies that recognize the costs associated with graduate medical education should not produce disruptive and radical shifts in the distribution of revenues among hospitals.

5. Any restrictions on payment should be sensitive to the effect these changes may have on the quality of educational programs and the ultimate competence of physicians in practice. Arbitrary limits on funding should be avoided.

The American Hospital Association is also pleased that the Council has identified a problem of great concern to hospitals -- the industry's limited voice in decisions to expand or lengthen residency training programs. AHA has initiated high level discussions with the American Medical Association, the Association of American Medical Colleges, and the American Board of Medical Specialties to seek ways to redress this problem. We expect these discussions to result in the preparation by the medical specialty boards, with consultation from the AHA and AAMC, of statements concerning the financial impact of changes in the training time required for Board certification. Discussions will also continue to ensure that these financial impact statements are reviewed early enough in the process to genuinely influence decisions concerning residency requirements.

It is also clear to the AHA that an increasing proportion of training will have to take place in non-inpatient settings, especially in the primary care specialties, to reflect the realities of the health care environment. While there are undoubtedly barriers which inhibit the appropriate use of ambulatory care settings for both graduate and undergraduate medical education, these barriers are probably not institutional in character. That is, by and large, institutions that sponsor ambulatory settings are receptive to the use of graduates and undergraduates in those settings. There are, however, significant numbers of institutions which do not have organized ambulatory programs and rely on physicians in private practice to provide outpatient care. These institutions and/or physicians may require financial incentives and assistance to successfully establish graduate medical education programs in the ambulatory facilities and program units under their control. Because of the complexity of this matter, the American Hospital Association supports the recommendation for demonstration projects.

The American Hospital Association is on record in opposition to further cuts in the indirect cost adjustment. There is a close correlation between those institutions with the highest case-mix severity index and teaching programs. Therefore, the existing indirect payment has been characterized as a proxy for a severity index. The treatment of the more severely ill patient involves the provision of referral services, and accordingly, large referral centers are potentially the most at risk if reductions are introduced in the indirect adjustment.

The American Hospital Association believes that the numbers and types of physicians trained should be guided by the health care delivery needs of both individual facilities and the nation as a whole. Our concern is that up until now national manpower considerations have not had sufficient influence on the distribution of physicians in general or within specialties.

Finally, given the charge to COGME, the American Hospital Association is puzzled by the recommendation for a major broad-based private sector review of the structure and content of undergraduate and graduate medical education. We believe that Congress expects such a study from COGME with the assistance of the affected constituencies. The American Hospital Association, as the representative of 5,400 of the nation's hospitals, and an important source of data stands ready to assist the Council to continue this study through testimony, contractual agreement, or staff-to-staff consultation. We look forward to the opportunity to work with you on these important issues in the near future.

Thank you.

TESTIMONY

PREPARED FOR PRESENTATION TO

THE COUNCIL ON GRADUATE MEDICAL EDUCATION

November 19, 1987

Council members, observers and guests, I am Dr. Michael Opipari from Detroit, Michigan. I am speaking upon behalf of the American Osteopathic Association (AOA), the American Association of Colleges of Osteopathic Medicine (AACOM), the American Osteopathic Hospital Association (AOHA) and the Academy of Osteopathic Director's of Medical Education (AODME). This presentation speaks for all three components of the osteopathic community, medical schools, hospitals and physicians.

The osteopathic profession includes 15 colleges of osteopathic medicine, 190 hospitals and 27,000 thousand physicians and students. This presentation includes a description of the profession and its education and clinical concerns as they relate to the agenda of this Council.

We strongly believe that for manpower planning purposes osteopathic physicians should be considered separately and not aggregated with allopathic physicians. There are two major reasons for this assertion. First, the osteopathic medical education system primarily produces family physicians. This is congruent with and acknowledged to be a public health goal for the United States. Family physicians are in short supply -- not over supply. We feel, therefore, there is no evidence to support a conclusion that there will be an over supply of osteopathic physicians for the foreseeable future.

Statistics on numbers, types and distribution of osteopathic physicians as well as hospital financing concerns were presented by the AOA and AOHA to the Council Subcommittee's on Physician Manpower and Financing at the hearings held last March 17, 1987 and June 29, 1987. Some eighty percent of all osteopathic physicians are practicing in the areas of primary care.

A second reason for separate consideration is osteopathic medical education. There is a shortage of osteopathic rotating internship (PGY-1) positions. The osteopathic graduating class has grown dramatically from four hundred in 1970 to sixteen hundred this year. It is essential that appropriate osteopathic postdoctoral training be accessible to each and every graduate. A funding mechanism should exist to assure that both hospital and ambulatory sites are available for this training.

The shortage of slots is not limited to internship positions, but is also found in osteopathic residency training. All funding mechanisms should assure the development and support of osteopathic residency programs, particularly in the area of primary care.

The osteopathic medical education model has been shown to be cost-effective. We present the following data:

Fact 1: Average Cost Per Trainee (Intern/Resident) Per Year.

Allopathic - Approximately $55,000 per year average.

Osteopathic - approximately $25,000 - $35,000 per year average. The major cost savings within the osteopathic model is due to use of essentially an entire volunteer faculty in the teaching hospitals. With the exception of three (3) college-owned hospitals, all other teaching hospitals are private and no faculty other than the Director of Medical Education is paid. The entire funding for the G.M.E. programs is only through the traditional pass-through mechanism (no practice plans, no grants, etc.).

Fact 2: Osteopathic Trainees in Primary Care Residency Training Programs in 1986.

1,337 = 48% D.O. residents in Family Practice residencies
+ 18% D.O.'s enter General Practice directly after PGY-I, which is an osteopathic rotating internship training year.
_____
66% D.O. Trainees in Primary Care (Family Practice)
Total number of D.O. residents = 2,793

Therefore, 66% of D.O. trainees are in Primary Care programs as opposed to only 40% of allopathic trainees.

Fact 3: Size of Osteopathic Training Hospitals.

Virtually all G.M.E. training sites are private hospitals with less than 300 beds (the majority have less than 200 beds), and with a community orientation (small and rural).

Fact 4: Average Osteopathic Trainee Salary.

Osteopathic interns and residents have traditionally had a significantly reduced salary structure compared to allopathic residents.

1986 - Osteopathic P.G.Y. I (intern) - $14,837
1986 - Allopathic P.G.Y. I - $23,600

This fact coupled with the non-paid G.M.E. faculty accounts for improved cost effectiveness of training an osteopathic resident. The marked differential in salary is also a reason for many osteopathic trainees selecting allopathic residencies. At the institutions with which I am affiliated we have recently created a $2,400 per year pay differential increase for primary care residents over non primary care residents.

Fact 5: Sites for Ambulatory Training in the Osteopathic Programs.

Virtually all ambulatory training experiences for osteopathic residents or interns occur in private practitioner offices (preceptor model), thus making the exposure real to community practice as opposed to medical center clinic. No trainer reimbursement occurs for the time expenditure of the training physician in spite of being slowed down by the trainee. No expense accrual thus occurs on the cost report of the program.

Fact 6: Reasons for the Success of the Osteopathic Primary Care Model.

(a) All osteopathic colleges have required general (family) practice clerkship rotations during clinical years, thus beginning exposure to the student.

(b) The required osteopathic rotating internship mandates a minimum of 50% time spent in primary care experience.

3 months internal medicine
1 months general practice
1 months pediatrics
1 months obstetrics and/or gynecology

(c) Effective role model practitioners:

(1) The 1978 Kellogg Report identified 88.5% of D.O.'s as primary care physicians. In spite of development of subspecialty training programs, certification board exams in addition to acceptance into allopathic fellowships, the family practice numbers in 1986 in the osteopathic profession remain very high at 66%.

(2) The Kellogg Report indicated 39% D.O.'s practice in communities with populations below 20,000, 50% under 50,000, and only 17% in communities over 500,000.

Fact 7: Since osteopathic training is producing the desired end product namely, a primary care (family practice) practitioner, in significant numbers, and there is an acknowledged under supply, there is little reason to consider D.O.'s in the aggregate of a physician surplus.

Of equal importance is an understanding of the osteopathic hospital system.

Osteopathic Hospital Profile

Osteopathic hospitals serve as the primary institutional care facilities for those patients who choose to receive their care from the 22,000 practicing osteopathic physicians nationwide. Like all hospitals, osteopathic hospitals are facing fierce competition in today's healthcare marketplace. With nearly half of our 190 institutions having less than 100 beds and 92% having less than 300 beds, the osteopathic hospital profile reflects a very special community orientation. Because of our inherently small size, our hospitals are especially vulnerable to changes in the marketplace. Since 1985, ten osteopathic hospitals have closed and two no longer retain their osteopathic identity. Of these, five were teaching hospitals. These losses are felt in communities where we provide a healthcare choice based on a distinctive medical philosophy that offers a holistic, "hands-on" approach. Osteopathic medicine offers an extra dimension of traditional healthcare.

The Osteopathic Teaching Hospital

The training of osteopathic physicians is a major concern for osteopathic hospitals. The continued funding of graduate medical education is essential to the number of training positions we can provide. Presently, all of our 129 teaching hospitals offer intern training and 70% provide residency training. Approved intern training programs within individual institutions and multi-hospital systems range from 2-86 positions. Approved residencies per hospital or system range from 1-101. The overwhelming majority of our teaching hospitals are community facilities and not academic health centers.

In fact, all of our community hospitals with 200-299 beds are teaching institutions, while 70% with 100-199 beds have teaching programs. Only three of the 15 osteopathic medical colleges currently operate teaching hospitals, giving further evidence that our programs are essentially community based.

The osteopathic teaching hospital role in training general practioners and specialists begins during the osteopathic medical student's undergraduate training. Our educational model stresses clinical exposure through clinical clerkships. This type of hands on clinical education is an essential ingredient to train the osteopathic physician. The osteopathic hospital has traditionally had primary responsibility for conduct of internships and residencies. Under the osteopathic graduate medical education model, all osteopathic physicians must enroll in a one-year rotating internship during which they receive clinical exposure in a multitude of areas. This rotating internship is required for program approval by the American Osteopathic Association (AOA) the accrediting arm of the profession, and for licensure in most states. This builds the foundation for the osteopathic physician to practice general medicine under all federal and state statutes with the exception of New Hampshire, where two years of post-graduate training is required for all physicians.

Residency training, especially in the primary care specialties, plays an important role in our teaching hospitals. The osteopathic first year of residency is actually equivalent to PGY II in allopathic training programs. (While our general practice model consists of a one-year rotating internship followed by one-year residency with an optional second year (three graduate years), other specialties require from two to six years additional training.)

There are 1,660 approved osteopathic intern positions for 1987-88, while 2,020 approved residency positions exist. We expect 1,601 graduating students to seek these positions in the coming year. While these figures appear positive. 281 intern positions are currently unfunded by hospitals, because of financial constraints and decreasing census. This places osteopathic hospitals in a jeopardy of not being able to train all incoming graduates in an osteopathic setting.

We are currently trying a work out these problems within the profession, but our options are limited. Any federal or state policy initiatives that limit payment for teaching purposes will further exacerbate our problems.

Other Distinctions Between Osteopathic and Allopathic Training Programs

In addition to the rotating internship which is unique to the osteopathic training model, there are other distinctions between osteopathic and allopathic training programs.

Nearly all of the faculty are volunteer, (no pay, no practice plans) as are specialty college and certification board members and personnel. Instructors also carry a full patient load in addition to their training responsibilities.

Besides all conventional medical procedures, students studying osteopathic medicine are specially trained to perform osteopathic manipulative therapy (OMT). OMT is a procedure in which osteopathic physicians use their hands to diagnose and treat muscular skeletal problems when indicated. This additional procedure, with special facilities established in the hospitals for its use, enables comprehensive osteopathic care to be rendered to hospital patients.

Osteopathic training programs are initially approved by the AOA's Committee on Postdoctoral Training - a body equivalent to the Accreditation Council for Graduate Medical Education. The AOA Board has final approval authority. Re-approval for residency programs is granted after periodic review by specialty college surveyors.

The Financing of Osteopathic Teaching Hospitals

The financing of osteopathic teaching hospitals comes primarily through third party reimbursement. There is essentially no grant support or other direct state or federal funding. For example, in 1987, only two federal grants were awarded to our teaching hospitals nationwide to support primary care specialty residencies (1 internal medicine, 1 pediatrics). In addition, only six general practice residencies received federal grant assistance. Therefore, private support through reimbursement by third party payers and patients themselves continue to be the only other funding sources available. Thus, additional federal cutbacks in funding would be devastating. Recent GME funding cuts have already resulted in the reduction of available internship and residency positions in some institutions. These cutbacks are felt more severely when coupled with the full implementation of the national prospective rate setting system and the anticipated budget cuts recommended by the administration. This will increase the pressure on an already taxed system due to insufficient available internship positions for the increasing number of osteopathic graduates.

Other Financing Considerations

The unique profile of the osteopathic training model presents additional financing considerations. If the current financing system is restructured. osteopathic teaching hospitals must be able to compete equally with allopathic GME programs for available funding despite the relative lack of resources, faculty trainers, and academic base of support. We must find mechanisms to make available necessary funding for osteopathic teaching hospital faculty development and for at least partial salary support for hospital teaching faculty and program directors. As our voluntary faculty faces increasing practice pressures and other demands, our hospitals will not be able to retain their traditional volunteer faculties.

We believe our concerns are justified especially since the Congressional Budget Office recently reported to you that osteopathic teaching programs in our hospitals are more cost effective than the allopathic model.

The osteopathic profession is under increasing pressure to develop and create alternative training programs in non-osteopathic community institutions. These are being administered through osteopathic medical colleges or through affiliations with other hospitals.

A continuing shrinking patient base coupled with increased competition for patients in community hospitals, is also resulting in less teaching opportunities. This may result in program and available position reductions especially with reduced reimbursement.

Issue Summation

As we have shown, osteopathic hospital based teaching programs by their very nature are smaller than others. They are community hospital based and currently stretched to the limit in their capacity to financially support the increased demand of osteopathic graduates. With an ever increasing influx of osteopathic medical school graduates, the traditional osteopathic teaching hospital finds itself faced with ever mounting pressures. The pressures are broadly based. Osteopathic graduates need intern and residency slots. Their concerns are real. Meanwhile, support for training is shrinking; the osteopathic hospital system is consolidating and tightening due to the contemporary economics of health care, with the result being that an increasing number of training opportunities are outside the osteopathic hospital. We strongly believe that if we are to have a pluralistic health care system with a real choice in medical practice and philosophy of care offered, then traditional osteopathic hospital and ambulatory based programs must continue to be supported as the site of first choice for graduate medical education training. This can't be accomplished without continued financial recognition. Even the slightest reduction can drastically reduce program size resulting in another osteopathic physician being forced to seek training from outside of his or her chosen profession.

The economics of health care precipitated by the Medicare prospective payment system, have led to a declining bed census and a dramatic growth in ambulatory services provided by osteopathic hospitals. Decreased caseloads in small teaching hospitals often mean refined training experiences and always mean less federal support.

In Pennsylvania, for example, osteopathic hospitals are finding that 32% of their medical education costs are not reimbursed.

This is leading to consideration by some hospitals to reduce the size of their programs. In Michigan, osteopathic hospitals find themselves in a highly charged and competitive market. This has presented a different problem: the need to significantly raise stipends to keep osteopathic graduates from training in more lucrative allopathic programs. Meanwhile, the Department of Health and Human Services is seeking a further chipping away of the base of support.

Conclusion:

Funding sources should continue to be available for adequate training opportunities at all levels of osteopathic medical education - the colleges, internship and residencies, and continuing education.

RECOMMENDATIONS

1. Alter physician reimbursement to emphasize cognitive skills over procedural skills. This will create an incentive to enter primary care training. Currently the incentive is counter productive.

2. Allow a higher reimbursement differential through direct medical education reimbursement in favor of primary care trainees to include osteopathic interns.

3. Allow bonus reimbursement to institutions with over "X" percent trainees in primary care, through the indirect payment adjustment.

4. Establish a definitive mechanism for reimbursement for the ambulatory training costs in community sites, with some reimbursement for the ambulatory training supervisor. Offer a mechanism and incentive for continued utilization of established community sites (osteopathic model).

5. Continue at least current mechanism and level of G.M.E. reimbursement pass through to training institutions in order to allow adequate P.G.Y. I (osteopathic internship) positions as precursors to continued primary care training.

6. Develop Council on Graduate Medical Education recommendations that consider osteopathic manpower supply both separately from the allopathic manpower supply as well as in the aggregate.

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Representing the National Association of
Community Health Centers

The National Association of Community Health Centers (NACHC) represents over 580 Community and Migrant Health Centers--including 1500 clinic sites and over 3,000 physicians--that provide primary care services throughout the country to the nation's six million poorest citizens, the majority of whom belong to minority populations. Although some nationally-based calculations indicate a physician "glut" in terms of some medical specialities, and sometimes of primary care disciplines in terms of geographic distribution, it has been NACHC's experience that there exists a distinct under-supply of primary care physicians, especially of minority physicians, in the inner cities and poor rural communities to meet the health care needs of America's poor. I would now like to speak from my own personal experience.

I have practiced medicine in Mississippi since 1960, first upon graduation from Meharry Medical College, and later upon completion of my pediatric residency in 1967 at the University of Mississippi Medical Center in Jackson. My opportunity to obtain a medical education resulted from a state loan program which had a payback provision which required practicing primary care for five years in an underserved area in Mississippi. To be frank, my original intention when I first returned to the state in 1960 was to complete my obligation and then leave, given the inter-racial climate at the time. Yet I soon learned there was an overwhelming need for more black physicians in the state, as there were only 47 black physicians in a state which had a black population of about one million. It became evident that there was a high correlation between being poor and being black and being sick. It was also clear that those physicians most likely to care for poor black patients were black. I therefore made the decision to remain in Mississippi, and I undertook a pediatric residency at the University of Mississippi, the first black to do so. I became increasingly concerned with the lack of minority physicians, as I noted the high number of cases of black infants and children admitted to the hospital who came from as far away as 200 miles because there was no one to care for them in their local communities. Then, with the assistance of a national black medical student association, we were able to identify between 45 and 50 blacks from Mississippi who were enrolled in medical school outside the state. We also become acquainted with a comprehensive health care facility sponsored by Tufts Medical School in the Mississippi delta. With resources from this program and the Mississippi Regional Medical Program, we brought these students back to the state for three consecutive summers to expose them to communities in desperate need for them to return to and practice in on completion of their medical education. Then the National Health Service Corps (NHSC) was established.

Since 1966, the number of federally-funded community health centers in Mississippi has increased from one to 21 such facilities today. *Not* coincidentally, the number of black physicians in the state has increased since 1966 from 47 to about *130* today. I can safely say that no less than 90% of these additional minority primary care physicians are in the state as a direct result of the combined efforts of these various medical manpower development programs.

Of particular significance is the fact that even those minority physicians who may have left health centers upon completion of their NHSC obligations have remained in poor areas and continue to serve those most in need. Continuation of such medical manpower development is crucial to the health care of Mississippi's and America's poor and minority citizens.

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Improved Funding of Graduate Medical Education in Rural Teaching Hospitals will Mean Better Patient Care

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Many rural areas remain medically underserved, despite an emerging, overall physician surplus. **One way to deal with this problem is to provide a differential federal payment allocation for small rural teaching hospitals, so that they can continue to set the standard of quality medical care for rural areas. This quality stems from** the academic milieu enabling recruitment of an excellent resident staff, along with **attracting and retaining a faculty whose enthusiasm for teaching and research becomes tuned to rural medical problems. An enduring rural health care network is thus assured**, in concert with the surrounding physician community. **One proven model for solving these problems is portrayed here. Its relatively small size, like most rural hospitals, is an asset**, allowing a highly personal approach to the educational process and an increased flexibility to deal with local problems. **But without increased financial support, the teaching approach it exemplifies will face a limited future.**

The Mary Imogene Bassett Hospital, located in an Upstate NY village with a population of 2400, was organized in 1927 as **a private, rural referral center with a full-time, salaried, physician staff, committed to house staff education and research as the background for patient care.** In the subsequent 60 years the hospital has achieved a national reputation for its teaching and for research related especially to rural health problems. Today it is a **regional, multi-disciplinary physician group practice** with 180 acute-care beds, and, in 1986, 6929 admissions, 49,507 patient days and 150,130 outpatient visits, drawn from a nine-county surrounding area and beyond. Medicare, medicaid and all other payor classification for admitted patients were 45, 13 and 42% respectively. The hospital successfully operates a health maintenance organization and thus provides an important, additional teaching model. About 80 fourth-year medical students elect rotations each year from 28 elective offerings, and sought-after residency programs include internal medicine, general surgery, psychiatry, a transitional year and rotations to Bassett from other medical centers in four additional disciplines. **Nine of 18 of the physicians running the hospital's 10 community clinics are graduates of its residency programs.** The staff also provides high-quality continuing education for physicians affiliated with surrounding community hospitals, along with a wide front of allied health and community education programs. **The overall operation resembles, on a small-scale, an Area Health Education Center** (characterized as such in 1970 by the Carnegie Commission on Higher Education), **with an advantage of being able to tailor objectives closely to local needs.**

Plans for graduate medical education at Bassett Hospital include continuation of current residency programs, expansion of medical student teaching and **project more teaching in outpatient clinics, including the network of 10 community centers.** However, the small size of the institution means that **unit costs tend to be higher than those of larger hospitals for providing the same range and quality of services necessary for both the educational program and optimal patient care:** the ratio of fixed to variable costs at Bassett is about 80/20 as opposed to larger, urban teaching hospitals at around 60/40. **This pressure puts educational programs in particular economic jeopardy** in relation to the finite limits for meeting overall institutional expenses. Added pressures include tightened ACGME requirements for small programs and new State regulations for house staff hours and supervision. **Without adequate funding, major cutbacks in the hospital's existing and planned graduate education programs are threatened.**

In summary, the cited "Bassett model" of medical education and care helps address the problems of recruiting and retaining physicians to provide high-quality care in rural areas. It is promoted as one innovative approach among others. But unless other effective, national funding methods can be established, **the best solution for supporting graduate medical education in rural teaching hospitals should be modification of the federal direct and indirect payment formulas in line with the economic realities of smaller institutions.**

*presented to the Public Hearing of the Council on Graduate Medical Education (COGME) at Bethesda, MD on November 20, 1987

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ORAL
STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Council on Graduate Medical Education

Presented by

Frank A. Riddick, Jr., M.D.

RE: Graduate Medical Education, Foreign Medical Graduates and Physician Manpower Issues

November 19, 1987

Mr. Chairman and Members of the Council:

My name is Frank A. Riddick, Jr., M.D. I am a member of the AMA's Council on Medical Education, and I am also an AMA representative to the Liaison Committee on Medical Education, the accrediting body for United States and Canadian medical schools. I have served as Chairman of the Accreditation Council for Graduate Medical Education, the accrediting body for U.S. graduate medical education programs, and as Chairman of the AMA Council on Medical Education. Accompanying me is Thomas Wolff of the AMA's Department of Federal Legislation.

The AMA is pleased to have the opportunity to testify before the Council on Graduate Medical Education. In the notice announcing this hearing, the Council identified questions in three areas that need to be addressed: physician manpower, foreign medical graduates, and the financing of graduate medical education. Because of limitations on time for oral presentation, my remarks today focus on the financing of graduate medical education. The AMA's written statement for the hearing record addresses this subject in more detail, as well as the issues of physician manpower and foreign medical graduates.

Mr. Chairman, the graduate medical education system in the United States is the benchmark against which other medical education systems are and should be judged. A key element in achieving this preeminent position has been the existence of stable funding mechanisms.

Over the past year COGME has heard varying and sometimes conflicting views concerning the financing of GME. In the statements, conclusions, and suggested recommendations issued after your October 5, 1987 meeting, we observe notes of caution and restraint which are commendable. We urge you to continue in this direction and develop thoughtful and reasoned recommendations concerning graduate medical education and its financing that will preserve the high quality of graduate medical education in this country and diminish the possibility of ill-advised or ill-informed actions by government and the private sector.

The AMA has developed the following principles concerning graduate medical education and its financing and we urge that you give them careful consideration in the development of any recommendations to Congress.

1. Graduate medical education is an essential component of the education of all physicians. Because the health and well being of the American people are directly and significantly benefited by the graduate medical

education of physicians, societal contributions to the financing of graduate medical education are not only appropriate but are in the best interest of society.

2. In residency training programs, the education of physicians and the clinical care of patients are inextricably linked. Thus, it is unproductive to attempt to factor out, as some would seek to do, the portion of a resident's time devoted to education.

3. Patient care revenues, derived from both public and private payers, should continue to be used as the predominant source of funding graduate medical education. All public and private payers of patient care costs should contribute their proportionate share of GME expenses.

A key benefit of the existing system of funding the majority of graduate medical education costs through patient care revenues is the stable financial environment that such funding has fostered. This predictable financial environment, in which teaching hospitals are assured that payment will be made for reasonable direct and indirect medical education costs, has been a major reason for the number of high quality teaching programs available.

Funding for GME should continue to be derived from other sources, including state government funds, the Veterans Administration, federal, state and private grants, institutional gifts, and endowment income. It is important to recognize, however, that no other source of funds, including faculty practice plans, is capable by itself of adequately supporting GME.

4. In a period of severe federal fiscal constraints, first priority for Medicare funding for graduate medical education should be given to graduates of medical schools accredited by the Liaison Committee on Medical Education or the American Osteopathic Association. If adequate federal resources are not available, it would be appropriate to eliminate Medicare support for the residency training of FMGs, both aliens and U.S. citizens. A gradual phasing out of Medicare support is essential to protect individual FMG residents already in training as well as hospitals and patients dependent on FMG residents.

5. Teaching hospitals should be reimbursed fully for their reasonable direct medical education costs, including the reasonable costs of residents' salaries and fringe benefits, as well as costs relating to faculty instruction of residents.

6. The Medicare indirect medical education adjustment should be continued at an adequate level. A substantial reduction in the indirect adjustment would have a severe adverse impact on many teaching hospitals, particularly inner-city and major teaching hospitals that provide substantial amounts of uncompensated or inadequately compensated care. In our view, care of the indigent, which is entwined in the indirect medical education adjustment, must be recognized specifically and paid for by separate mechanisms.

7. Support for both direct and indirect medical education costs must include residents assigned to ambulatory sites that are required components of educational programs. Given the strong trend toward providing care in the outpatient setting, and the desire to increase the number of physicians entering the primary care specialties, it would be particularly inappropriate to penalize hospitals for placing residents in ambulatory care sites.

8. Individual billing by residents for their services as a means of reducing the direct costs of graduate medical education should not be fostered. Such billing could interfere with supervised education upon which program accreditation depends.

9. Direct federal financing assistance for primary care residency programs in the areas of family medicine, general internal medicine and general pediatrics, should be continued. Abrupt withdrawal of support for these programs could be highly disruptive and impede the development of manpower in the primary care areas of practice.

10. Residency training should be available to every graduate of a U.S. medical school. Graduates, however, cannot be guaranteed their choice of specialty and location.

11. Residents should receive reasonable compensation in all training programs. Uncompensated and under-compensated programs should be discouraged.

In concluding, the AMA supports the recommendations of the Council's subcommittee that advocate the continuation of the current mechanisms of funding graduate medical education. In the final analysis, these mechanisms will remain the simplest to administer and to monitor. We urge the Council not to consider any new mechanisms for payment which will be complicated, burdensome, and costly to implement.

Mr. Chairman, my comments have stressed societal responsibility to support graduate medical education and the obligation of government and the private sector to preserve the nation's teaching hospitals. We must note, however, that the configuration and the size of the graduate medical education system must at any point in time reflect anticipated health care needs of the American people. Institutions must conduct internal examinations of the programs they sponsor, assess the need for specific programs and determine the numbers of residents in these programs. The entire graduate medical education system should provide sufficient opportunities for all U.S. medical school graduates and sufficient flexibility to allow a measure of career choice.

The private sector, led by the major professional organizations, must continue to examine the graduate medical education system with urgent attention to the mechanisms by which added requirements for specialty training are reviewed and adopted.

The AMA commends COGME for holding this hearing and appreciates the opportunity to testify. We believe that before each Subcommittee makes its final recommendations, a public hearing should be held at which interested parties may present their views.

Mr. Chairman, I will be happy to answer any questions members of the Council have.

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STATEMENT

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AMERICAN MEDICAL ASSOCIATION

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Council on Graduate Medical Education

Presented by

Frank A. Riddick, Jr., M.D.

Re: Graduate Medical Education, Foreign Medical Graduates
and Physician Manpower Issues

November 19, 1987

Mr. Chairman and Members of the Council:

My name is Frank A. Riddick, Jr., M.D. I am a member of the AMA's Council on Medical Education, and I am also an AMA representative to the Liaison Committee on Medical Education, the accrediting body for United States and Canadian medical schools. I have served as Chairman of the Accreditation Council for Graduate Medical Education, the accrediting body for U.S. graduate medical education programs, and as Chairman of the AMA Council on Medical Education. Accompanying me is Thomas Wolff of the AMA's Department of Federal Legislation.

The AMA is pleased to have the opportunity to testify before the Council on Graduate Medical Education (COGME). In the notice announcing this hearing, the Council identified questions in three areas that need to be addressed: physician manpower, foreign medical graduates, and the financing of graduate medical education. These questions identify numerous issues that need to be addressed as the Council proceeds under its ten-year charter to make recommendations concerning physician training. As you are aware, not all of the questions you have posed have clear answers today and some may require years of research to provide the data needed. We commend you for your thoughtful inquiry and will touch on all three areas in our statement.

GRADUATE MEDICAL EDUCATION (GME)

The AMA believes strongly that the graduate medical education system in the United States is the benchmark against which other medical education systems are and should be judged. It is a system that encourages excellence, dedication and knowledge. A key element in achieving this preeminent position has been the existence of stable funding mechanisms.

Over the past year COGME has heard varying and sometimes conflicting views concerning the financing of GME. In the statements, conclusions, and suggested recommendations issued after your October 5, 1987 meeting, we observe notes of caution and restraint which are commendable. We urge you to continue this direction and develop thoughtful and reasoned recommendations concerning graduate medical education and its financing that will preserve the high quality of graduate medical education in this country and diminish the possibility of ill-advised or ill-informed actions by government and the private sector.

The AMA has developed the following principles concerning graduate medical education and its financing. We urge that you give these principles careful consideration in the development of any recommendations to Congress.

1. Graduate medical education is an essential component of the education of all physicians.

The education of physicians is a long and arduous process requiring years of classroom work with increasing exposure of students and physicians-in-training to the practical aspects of patient care. The first years of education in medical school focus generally on the basic medical sciences in classroom and laboratory experiences. As medical education progresses, when students study clinical sciences, there is increasing integration of the student into the patient-care team at the bedside and in ambulatory settings. After graduation from medical school, intensive participation in patient care begins as a part of graduate medical education. Graduate medical education, commonly referred to as residency training, places the physician-in-training in a learning and service environment in which he or she receives "hands on" experience by caring for patients under the supervision of licensed physicians/teachers. The resident participates in the diagnosis and management of large numbers of patients who present a wide spectrum of disease conditions. The training program is designed to offer the resident increasing levels of responsibility to prepare him or her for the independent practice of medicine. In this way the resident acquires the requisite knowledge and skills of his or her chosen specialty.

2. Societal contributions to the financing of graduate medical education are appropriate and in the best interest of society.

Teaching hospitals and their residency programs provide a number of significant benefits to the general public. Certainly, all of society benefits from having an adequate supply of highly trained physicians in all medical specialties. In addition, teaching hospitals generally have more special care units such as units to treat burns or heart attack than do non-teaching hospitals. As a result, teaching hospitals often serve as the medical referral center for an area, offering tertiary care unavailable elsewhere in a community. Finally, residents under the supervision of attending physicians provide quality patient care. In the absence of residents, hospitals would be forced to utilize increased numbers of practicing physicians thereby increasing the cost of services.

Because the health and well being of the American people are directly and significantly benefited by the graduate medical education of physicians, societal contributions to the financing of graduate medical education are not only appropriate but are in the best interest of society. Moreover, it would be unfair to exclude the costs of residents' services from the health care price structure when, in the price of many goods and services, Americans pay for the educational expenses incurred by companies in the training and retraining of workers.

3. In residency training, the education of physicians and the clinical care of patients are inextricably linked.

Resident physicians provide care for patients in the course of which their knowledge and skills are advanced. Since education and patient care are so interwoven, it is difficult, if not impossible, to separate the learning and service components of graduate medical education. Thus, the AMA opposes as unproductive attempts to factor out the portion of a resident's time devoted to education.

4. Patient care revenues should continue to be the primary source of funding graduate medical education. Funds from other sources must also continue to be available to support residency training.

Currently, patient care revenues account for over 80% of the financing of graduate medical education. The AMA strongly supports the continued use of patient care revenues, derived from both public and private payers, as the predominant source of funding graduate medical education for all residents, foreign medical graduates as well as graduates of U.S. medical schools.

A key benefit of the existing system of funding the majority of graduate medical education costs through patient care revenues is the stable financial environment that such funding has fostered. This predictable financial environment, in which teaching hospitals are assured that payment will be made for reasonable direct and indirect medical education costs, has been a major reason for the number of high quality teaching programs available. Also, as noted above, residents provide services that are directly attributable to patient care.

The AMA supports continued funding for GME from other sources, including state government funds, the Veterans Administration, federal, state and private grants, institutional gifts and endowment income. It is important to recognize, however, that no other source of funds, including faculty practice plans, is capable by itself of adequately supporting graduate medical education.

5. Teaching hospitals should be reimbursed fully for their direct medical education costs by all public and private payers of patient care expenses.

Teaching hospitals should be reimbursed fully for their reasonable direct medical education costs including the reasonable costs of residents' salaries and fringe benefits and of faculty instruction of residents. The AMA strongly opposes limiting Medicare reimbursement for direct medical educations costs to a specified number of years. We are concerned that many teaching hospitals will be unable to make up shortfalls in Medicare support for residents in long training programs.

The AMA believes strongly that all public and private payers of patient care costs must contribute their proportionate share for GME expenses. For example, it is unfair for health maintenance organizations and preferred provider organizations to enter into contracts with teaching hospitals that allow them to avoid paying their fair share of GME costs. Such action increases the financial burden for all other payers.

6. The Medicare indirect medical education adjustment should be continued at an adequate level.

The Medicare indirect medical education adjustment is intended to compensate teaching hospitals for costs indirectly related to the teaching of residents. These costs include the fact that teaching hospitals treat more complex and severe cases, provide more technologically intensive care, and provide more uncompensated or insufficiently compensated care to low-income and indigent patients. In addition, because teaching hospitals usually contain many special care units, overall occupancy rates may be lower than those of non-teaching hospitals where beds may be available for general admission.

The AMA supports continuation of Medicare's indirect medical education adjustment at 8.7% calculated on a curvilinear basis. Under a curvilinear approach, while a hospital's indirect medical education payment would continue to increase as its ratio of interns and resident-to-beds increases, the rate of increase would be smaller with each incremental increase in the resident-to-bed ratio.

We oppose proposals that would reduce significantly the indirect medical education adjustment. A substantial reduction in the indirect adjustment would have a severe adverse impact on many teaching hospitals, particularly inner-city and major teaching hospitals that provide substantial amounts of uncompensated or inadequately compensated care.

In our view, care of the indigent, which is entwined in the indirect medical education adjustment, must be recognized specifically and should be paid for by separate mechanisms.

7. Support for both direct and indirect medical education costs must include residents assigned to ambulatory care sites that are required components of educational programs.

Clinical education in ambulatory sites is a mandated component of many residency programs. We are concerned regarding proposals or policies that would refuse to count residents who work in ambulatory care sites. Such policies would serve as a disincentive to hospitals to place residents in those sites possibly resulting in reduced primary care residency programs. Given the strong trend toward providing care in the outpatient setting, and the desire to increase the number of physicians entering the primary care specialties, it would be particularly inappropriate to penalize hospitals for placing residents in ambulatory care sites.

8. Resident physicians should not be permitted to bill directly for patient services.

The AMA opposes proposals to allow resident billing as a means of reducing the direct costs of graduate medical education because such billing would adversely affect the graduate medical education system. Of special concern is that resident billing could interfere with supervised education upon which program accreditation depends. In addition, such billing would compete with faculty practice plan billing on which medical schools depend financially. Finally, billing by residents would likely increase the cost of medical care.

9. Direct federal financial assistance for primary care residency programs should be continued.

Currently, the federal government provides direct financial assistance to selected residency programs through grants under Title VII of the Public Health Service Act. This money supports residency training in the areas of family medicine, general internal medicine and general pediatrics.

The AMA supports continued federal assistance for these important residency programs. This financial support was initiated by Congress to place greater emphasis on training in these primary care specialties. With the widespread belief that the number of primary care physicians should be increased, it would be inappropriate to eliminate funding for these residency programs. Moreover, abrupt withdrawal of support for present programs could be highly disruptive and impede development of manpower in the primary care areas of practice.

10. Residency training should be available to every graduate of a U.S. medical school.

The configuration and the size of the graduate medical education system should at any point in time reflect anticipated health care needs of the American people. Teaching hospitals must conduct internal examinations of the programs they sponsor, assess the need for specific programs and determine the numbers of residents in these programs.

The entire graduate medical education system should provide sufficient opportunities for all U.S. medical school graduates. In addition, the number of available positions should be adequate to offer a measure of flexibility for graduates in the choice of institutions and the area of specialization. Graduates, however, should not be guaranteed their choice of specialty and location.

11. In a period of severe federal fiscal constraints, first priority for Medicare funding for graduate medical education should be given to graduates of medical schools accredited by the Liaison Committee on Medical Education or the American Osteopathic Association.

In recent years, proposals have been advanced to eliminate Medicare funding for the residency training of graduates of foreign medical schools. In light of severe federal fiscal constraints, it would be appropriate to eliminate Medicare support for the residency training of graduates of foreign medical schools, both U.S. citizens and aliens. In our view, a gradual phasing out of Medicare support for FMG training would be needed to allow individual FMG residents already in training to complete their residency and to enable hospitals dependent on FMGs to meet current patient care needs.

12. Residents should receive reasonable compensation in all training programs. Uncompensated and under-compensated programs should be discouraged.

The average annual salary of residents is $24,300. This amount is certainly not excessive in light of residents' education and training, the long hours they work, and the market value of the care rendered, particularly in the later years of training.

We are concerned that to avoid revenue shortfalls, program directors may offer uncompensated residency positions or positions compensated below institutional norms. In our view, these measures should be actions of last resort since they could compromise the quality of educational programs, diminish the value of residents' services, and make more difficult residents' legitimate efforts to secure reasonable compensation. We also oppose as ill-conceived proposals to impose tuition on residents.

Mr. Chairman, the AMA believes strongly that the graduate medical education system in the United States is second to none and is an essential component for assuring high quality health care for the American people. A key element in achieving our preeminent position in GME has been the existence of stable funding mechanisms. The AMA cautions you against proposing major changes in the system of financing graduate medical education. An ill-advised change could threaten our country's ability to train qualified physicians to meet our health needs in the future.

FOREIGN MEDICAL GRADUATES (FMGs)

Effect of Removal of FMGs

Currently, there are about 12,000 foreign medical graduates (FMGs) in residency training programs in the United States. Over half of these residents are training in the primary care specialties. FMGs are heavily concentrated in the states of New York, New Jersey, Michigan, Ohio, Connecticut, Maryland, and Pennsylvania. A significant reduction in the number of FMGs or the complete elimination of FMGs from residency programs would likely have a very disruptive effect on the availability of hospital-based services, especially primary care services in these states. Particularly hard hit would be hospitals located in large urban areas. In our view, if a reduction of FMGs in residency programs is initiated, a gradual phase out is needed to allow individual FMG residents already in training to complete their residency and to enable hospitals dependent on FMGs to meet current patient care needs. In addition, we do not believe it is appropriate for accrediting agencies to play a role in efforts to reduce the number of FMGs in residency programs. The sole purpose of accrediting agencies is to ensure quality.

GME for International Exchange Visitors

The AMA believes strongly that the United States should continue to provide graduate medical education opportunities for international exchange visitors who will then return to their native country to practice. To this end, the AMA and other major health organizations have recently developed a plan for an International Medical Scholars Program (IMSP) that will provide educational opportunities in the United States.

These FMGs will then return to leadership positions in research, practice, teaching, and administration in their native countries. The IMSP will enable the United States to resume its position of leadership in international medical education. It will also fulfill long-held moral and social obligations to international health.

Accreditation of Foreign Medical Schools

We are very concerned regarding the quality of medical education received by individuals at many foreign medical schools. A 1985 General Accounting Office report found that an increasing number of Americans are being trained in foreign medical schools, the quality of which are not subject to a clear set of standards to assure that graduates are qualified to provide medical care in the United States. Thus, we support any workable plan for the accrediting of foreign medical schools. Such accreditation, preferably located in the private sector, should help ensure that FMGs receive a medical education that is comparable to that provided in United States medical schools.

The AMA is actively assisting regional efforts, particularly in Latin America, to develop accreditation standards.

Additional Mechanisms for Evaluating FMGs

The AMA also believes strongly that in order to ensure that graduates of foreign medical schools have the necessary clinical and communication skills, additional mechanisms for evaluating FMGs prior to their entry into graduate medical education should be developed. Currently, an FMG must have his credentials validated, pass an English proficiency test that emphasizes written comprehension, and pass the Foreign Medical Graduate Examination in the Medical Sciences before beginning residency training. In order to guarantee the quality of FMGs prior to their entry into graduate medical education, two additional criteria should be met. First, FMGs should be required to pass an examination that demonstrates their clinical skills. Second, FMGs should be required to show verbal competency in the English language.

PHYSICIAN MANPOWER

The AMA recently examined the issue of physician manpower. In the following discussion we address many of the issues raised by COGME in the September 18, 1987 Federal Register notice.

I. MEASURING THE ADEQUACY OF PHYSICIAN SUPPLY

The threshold question is whether the supply of physicians in the U.S. is adequate to meet the country's need for physician services. In our view, "need for physician services" and "adequacy of physician supply" are extremely complex concepts that are not easily measured. A thorough review of the literature shows that a variety of methodologies are used to analyze this issue.

The AMA reviewed the various methodologies used to measure the adequacy of physician supply and evaluated the advantages and disadvantages of each. These methodologies can be grouped into five broad categories. In order of their complexity, they are:

- physician-to-population ratios;
- measures of physician accessibility;
- professional and community satisfaction;
- econometric analyses; and
- professional standards.

None of these methodologies provides a completely satisfactory standard by which to measure the adequacy of physician supply. Furthermore, the various methodologies do not always produce a consistent picture about whether there are too many or too few physician to meet the country's needs. However, in spite of their shortcomings, the methodologies play a necessary role in the formulation of physician manpower policy. They represent the different sources of information upon which policy makers base their beliefs and judgments about the adequacy of physician supply. Consequently, it is important to develop a thorough understanding of the different methodologies and to be fully aware of their relative strengths and weaknesses.

Physician-to-Population-Ratios

The physician-to-population ratio is the most commonly used indicator of the adequacy of physician supply. This ratio, usually expressed as the number of active physicians per 100,000 population, is a useful index in analyzing the availability of physician services across geographic areas or between different points in time.

The chief advantages of physician-to-population ratios are that they are easy to compute and have broad intuitive appeal. Also, these ratios have been adapted for many different types of studies. For example, physician-to-population ratios can be calculated for individual specialties or for the population of a specific age-group. These types of analyses are often used to locate shortage (or surplus) areas for physicians of a given specialty. When the ratios are used in this context, care must be given to address the level of services appropriate to the locale.

Analyses of physician-to-population ratios are complicated by the fact that not all physicians have the same level of productivity and not all segments of the population have the same demand for physician services. Physician productivity is influenced by a wide variety of factors, including physician sex, age, and modality of practice. Similarly, the demand for physician services is influenced by the age and sex distributions of the general population. To some extent, the variation in productivity and demand can be incorporated into the study of physician-to-population ratios by analyzing full-time-equivalent (FTE) physicians and by making adjustments for the effects of population composition. Comparisons of the ratios may be misleading if these factors are not taken into consideration.

Simple analyses of projected trends in the physician-to-population ratio do not take into consideration that the aging of the U.S. population may cause the demand for physician services to increase faster than the growth rate of the general population. Also, such analyses do not take into account the wide variety of factors influencing physician productivity, such as the changing modes of health care delivery, and the impact of future technological innovations.

Perhaps the most significant shortcoming in the use of physician-to-population ratios is that they do not provide normative standards for determining the adequacy of physician supply. That is, they do not by themselves indicate whether the supply of physicians is inadequate for, in parity with, or in surplus of the population's need for physician services.

Measures of Accessibility

The adequacy of physician supply is often related to the public's accessibility to physician services. This accessibility depends not only on physician supply, but also on the geographic and specialty distributions of the physician population and the availability of physicians to the public -- i.e, whether patients can see physicians when and where they wish. Accessibility to physician services depends on many factors, including:

- whether local physicians accept new patients;
- distance between the patient's home and the physician's office;
- lead time required for an appointment;
- waiting time in the physician's office before an appointment;
- convenience of office hours; and
- the amount of time physicians spend with patients.

Accessibility to physicians' services is an important concept in influencing the public's perceptions about the adequacy of physician supply. Nevertheless, the relationship between physician supply and accessibility is very complex, partly because the geographic distribution of physicians is much different from that of the general population.

In some rural areas, physicians are still in short supply. Patients often do not have adequate accessibility to physician services because of the long distances between their homes and physician offices. However, several studies have shown that the maldistribution of physicians has eased in recent years. A recent analysis by Newhouse, et al. shows that the expanding physician supply has led many physicians to move to small towns and cities where no physician of their specialty had practiced previously. Thus, the analysis indicates that recent growth in the physician population has improved the geographic accessibility of physicians in rural areas. However, it is not realistic to expect that continued growth in physician supply will correct completely this problem.

Physician accessibility is also determined by the availability of physicians to their patients in terms of the lead time needed for an appointment, the average amount of waiting time in a physician's office, and the amount of time physicians spend with patients during an average patient visit. Data from the AMA's Socioeconomic Monitoring System (SMS) show that between 1982 and 1985 the average lead time needed for an appointment decreased from 6.9 to 6.2 days. However, little change is seen either in the SMS data for the amount of waiting time at the physician's office or in data from the National Ambulatory Medical Care

Survey on the duration of office visits. While these data on physician availability are interesting in their own right, the AMA does not believe that they should be used by themselves for the purpose of analyzing physician supply.

Professional and Community Satisfaction

Researchers and policy makers often base their beliefs about the adequacy of physician supply on whether the general public (and/or physician population) perceives the supply of physicians to be adequate. In these studies, additional surveys are used to measure a population's degree of satisfaction with existing physician supply. If both the general public and physician population are satisfied, one would conclude that the supply of physicians is adequate.

The main advantage of working with this type of data is that it provides the most direct information possible about the public's perceptions about the adequacy of physician supply. However, there are several disadvantages. Most of the public is not well-informed about the supply of physicians, and certain segments of the population may have unreasonable expectations about how many physicians can be supported in a given community.

It is difficult to interpret disagreements among different segments of the general public or between the general public and the physician population. Also, decisions have to be made about what level of satisfaction is necessary for the physician population to be considered adequate. Consequently, it is difficult to develop a normative standard on the adequacy of physician supply with this sort of attitudinal data.

Data from recent AMA attitudinal surveys show that in 1984 the majority of the general public (59%) believed there was about the right number of doctors in their community; 12% thought there were too many doctors, and 26% thought there were too few. In general, the perceptions of physicians about the adequacy of physician supply were less sanguine than those of the general public. Nearly half (43%) believed there were too many physicians in their community, and 74% believed there was a current or impending surplus of physicians in certain specialty areas in their community. These views were also reflected in analyses of individual specialties. For instance, in a 1982 study of orthopedic surgeons, 42% said there were too many members of their specialty in their community and the same proportion said their surgical practices were operating below capacity.

The AMA is also concerned about the attitudes expressed by some physicians toward the current professional environment. The AMA believes that physicians' professional satisfaction is determined, in part, by their ability to effectively utilize the skills they have developed. The increasingly competitive environment has caused some physicians to shift from their specialty of choice and consequently has limited their professional satisfaction.

Econometric Analyses

The methodologies described above do not take into account how market forces affect the demand for medical services and influence beliefs about whether the supply of physicians is adequate. However, several recent studies have drawn inferences about the adequacy of physician supply by analyzing the relationship between physician supply and physician income. These studies can be divided into two groups.

- Analyses of "relative income" compare the average annual income of physicians to the incomes of other professions. One infers that the supply of physicians is increasing relative to demand whenever the incomes of physicians decrease relative to the salaries of individuals in comparable professions.

- Analyses of the "rate of return to medical education" consider medical education as an investment in human capital, and physician income is considered to be a return on that investment. According to these analyses, an increase in the supply of physicians relative to demand is associated with a decrease in physician income relative to the cost of a medical education.

Unfortunately, there is little consensus among these studies about whether there is currently a surplus of physicians.

A general criticism of the econometric approach to analyzing physician supply is that it focuses on the "demand" for physician services rather than on the concept of "need." However, it is essential that "need" and "demand" be measured if a complete analysis of physician supply is to be obtained.

Professional Standards

Of the five different approaches to measuring the adequacy of physician supply, only the professional standards approach is truly normative, providing an estimate of the number of physicians required to satisfy a population's "need" for health care. The methodology for this approach, developed by Lee and Jones in 1933, requires the following four pieces of information:

- estimates of how frequently each type of illness occurs in a given population;

- perceptions of a panel of experts regarding the amount and type of health services required to treat each type of illness;

- the panel's perceptions on the amount of time required to provide each type of service; and

- their perceptions of the average amount of time different types of providers spend in patient care.

The professional standards methodology was further adapted in the Graduate Medical Educational National Advisory Committee (GMENAC) study to project future requirements for physicians. The GMENAC study used an "adjusted needs" based model to estimate these requirements. Panels of experts analyzed data on the prevalence of disease to estimate future need for health care services. These estimates were adjusted to take into account societal barriers and constraints preventing the delivery of these services, and then the "adjusted needs" for health services were allotted among physicians and other health professionals. Data on the content and productivity of physician practices were used to calculate future requirements for physicians in each specialty, and these projected requirements were then compared with the projected supply of physicians.

The large amount of complex information required by the professional standards approach is a major disadvantage of this type of analysis. In the process of developing estimates and setting standards, it is necessary to resolve many issues in a fairly arbitrary fashion. Decisions must be made on a wide variety of issues, including sometimes tacit assumptions about how the quality of care varies (or is the same) among different providers. Furthermore, when the professional standards approach is used to project the need for physicians at some future date, the analyses require arbitrary assumptions about future trends in the prevalence of disease and treatment regimes. These arbitrary decisions are ultimately reflected in the projections of need.

Another difficulty with the professional standards approach is that it has traditionally been built around the concept of the epidemiological "need" for health care without proper consideration of economically determined "demand." Estimates of physician requirements based on "need" will be overstated if society will not finance the physician services deemed necessary to meet those needs.

The findings of the GMENAC study give strong support to the perception of a physician surplus. Its analysis estimated that there would be a surplus of 70,000 physicians by 1990 and a surplus of 145,000 physicians in 2000. The study found that in 1990 most specialties would have an oversupply. Several specialties would be in near balance, including the primary care specialties of family practice, general internal medicine, and general pediatrics. Shortages were projected for psychiatry, physical medicine and rehabilitation, preventive medicine, and emergency medicine.

On the basis of these findings, GMENAC made 40 recommendations, including:

- a 17% decrease in medical school enrollment;
- further restrictions on the entry of foreign medical graduates into the U.S.; and
- no further increases in the number of allied health professionals being trained.

The GMENAC findings proved to be very controversial. The methodology of the study was criticized for a wide variety of reasons, including: the inadequacies of the data utilized; the arbitrary assumptions embodied in models used to estimate "need" for health care; and problems in the organization of the expert panels used to estimate the requirements of services. Despite these criticisms, the GMENAC study has proved to be the most important projection of physician requirements in recent years, setting a standard to which other such projections are compared.

Complexities in Measuring the Adequacy of Physician Supply

The application of these methodologies to the U.S. health care system produces little consensus about the adequacy of physician supply. This lack of consensus is largely because "need for physician services" and "physician productivity" are nebulous concepts, and there is little agreement on how they should be defined or measured.

The "need for physician services" is influenced by a wide variety of factors, including:

- amount and distribution of illness;
- the sociodemographic characteristics of the general population;
- the method of health care financing; and
- population lifestyles.

Changes in these factors make it difficult to estimate future need for physician services. On the one hand, the aging of the general population will increase the need for many types of physician services. However, owing to other developments, this increase in need may not be fully satisfied. In recent years, there has been increasing pressure to reduce payment for services covered by Medicaid and Medicare due to the growing fiscal conservatism of the federal government together with increases in national expenditures for health care. Further cuts in the Medicare program may reduce the impact of the aging population on demand for physician services. In addition, healthier lifestyles of the general population and the greater use of preventive health care are also likely to reduce future demand for physician services.

The adequacy of physician supply is also determined by factors affecting physician productivity, such as the: number of patient visits per week; number of hours per week worked by physicians; mode of health care delivery; and technical innovations.

Physician productivity is also influenced by the mode of health care delivery. The ratio of physicians to patients in health maintenance organizations (HMOs) is considerably lower than the general physician-to-population ratio for the entire U.S. Consequently, the growing prevalence of these types of payment systems will increase effective physician supply. A recent study by Steinwachs, et al., compared staffing patterns of primary care physicians in three HMOs with the national requirements for physicians projected for 1990 by GMENAC. The analysis showed that when the data from HMO staffing requirements were incorporated into the GMENAC methodology, the projected physician requirements would be reduced 20% for pediatricians and 50% for primary care physicians treating adults. These findings indicate that there would be a significant reduction in the number of required physicians in the U.S. if the entire U.S. population were to be enrolled in HMOs and if HMOs maintain their relatively low physician-patient staffing ratios.

The relationship between physician supply and physician productivity is further confounded by changes in the composition of the physician population. The number of female physicians is projected to increase by 90 percent between 1985 and 2000 in contrast to a 25 percent increase in the number of male physicians. Women physicians have traditionally worked fewer hours and have had fewer patient visits per week than male physicians. AMA data indicate that female physicians have lower productivity than male physicians, working 90 percent as many hours per week in patient care activities and having 75 percent as many patient visits per week. If this sex differential persists, a small proportion of the projected increase in physician supply will be offset by the growing proportion of female physicians. However, recent studies indicate that differences in the productivity of male and female physicians have decreased in recent years.

Technological innovations in medical care are also likely to have a strong impact on the effectiveness of physician supply, although it is difficult to predict what the net effect of these innovations will be. In some cases, the development of new procedures or treatment regimes will increase overall patient demand for physician services, thereby absorbing part of the projected physician surplus. In other cases, a newly developed procedure or treatment will replace several less efficient ones, thereby increasing the effectiveness of physician supply.

Concerns About a Physician Oversupply

A major concern of the AMA is that a surplus of physicians could lower the quality and raise the costs of physician services. There are several reasons for this concern. First, it is possible that as competition among health care providers becomes more intense and as the volume of physician practices shrink, physicians may not perform certain procedures frequently enough to maintain a high level of skill. As of yet, no study has analyzed the relationship between the size of a physician's practice and the quality of care. However, in related research it was found that better outcomes for surgical patients were more likely in high-volume hospitals.

A second area of concern is the large amount of primary care in the United States that is actually provided by physicians trained in nonprimary care specialties. As competition in the health care delivery system increases, a growing proportion of specialists may start providing primary care in order to compensate for the lower demand for specialty services. Since specialists tend to charge more than generalists for comparable services, and have a more technology-intensive approach to treatment, the cost of primary care would increase without necessarily improving quality.

Third, at least part of the increase in the nation's health care expenditures has been related to increases in supply. Recent studies have shown that the larger supply of physicians has resulted in higher expenditures for health care. Sloan and Schwartz estimated that 22% of the increase in real annual expenditures for physician services between

1970 and 1979 was related to an increase in the physician-to-population ratio. (This finding does not connote that the added services are unnecessary or inappropriate. It is equally logical to conclude that the increase in supply results in better access to needed services.)

Finally, a significant part of the recent growth in physician supply has been due to physicians trained in foreign medical schools. The AMA is concerned about the quality of training provided by some foreign medical schools. Allowing physicians who do not have adequate medical training to practice in the U.S. will have a negative impact on the quality of health care in this country.

II. OVERVIEW OF PHYSICIAN MANPOWER POLICIES

A wide variety of policies has affected the supply of physicians during the last two decades. This section provides an overview of these policies. The first part describes three broad categories of physician manpower policies, and the second part describes how these policies have affected the supply of physicians since the late 1960s.

The AMA reviewed a wide variety of physician manpower policies. These policies can be grouped into the following three broad categories based on the locus of decision-making:

- market-oriented policies, which favor decentralized decision-making by physicians and patients;
- public initiatives, in which the authority to make decisions is centralized in state and federal governments; and
- private initiatives, in which policy decisions are made by nongovernmental bodies, including health care organizations such as the AMA.

In practice, manpower policies are combinations of each of these three categories which are described in more detail below.

Market-oriented policies. Market-oriented policies rely on the discretion of individual physicians and patients to make the decisions that are best for their personal needs. Patients are free to choose their providers and the amount of care they are willing to purchase. Physicians are free to choose the mode and location of their practices and to determine the fees for the services they provide. The market controls the number of physicians and is permitted to increase or decrease with the attractiveness of medicine relative to comparable professions.

In the past, the AMA has advocated market-oriented policies because they offer maximum autonomy to physicians and other health providers, and they allow patients to choose their providers and the amount of care they wish to receive on the basis of their own personal preferences. Furthermore, market-oriented policies tend to be self-regulating. However, the self-regulating aspects of the marketplace work most efficiently in an environment free of external regulations, and there has not been a regulation-free medical care market in recent years.

Since the 1960s, market-oriented policies have generally not been used to determine the size of the physician population. Entry into the profession is largely controlled by policies set in the public sector (e.g., determination of class size of universities, immigration policies and funding for training programs). Many of these policies artificially encourage the production of physicians, and interfere with the self-regulating aspects of market-oriented policies.

Public initiatives. Government policies influence the supply of physician manpower in a number of ways -- through state and federal government subsidies for medical education, through immigration laws which determine the number of foreign-born physicians, through the licensing of physicians, and, indirectly, through government programs that have increased the demand for physician services.

While the AMA recognizes the legitimate role of state and federal governments in the health care system, we strongly oppose government regulations which restrict the professional autonomy of physicians. Such regulations often exacerbate problems instead of eliminate them.

Private initiatives. The AMA, along with other health organizations, is involved in many different aspects of physician manpower policy. The various aspects of the AMA's manpower policy are based on the AMA's primary goal to provide quality medical care to the American people. The following three types of activities are consistent with this desire:

- working with other organizations, including state and federal governments, to develop policies that are consistent with quality health care;
- analyzing and disseminating information about trends in the health care delivery system; and
- creating programs to help individual physicians provide better care by increasing the efficiency of their practices.

The three types of activities described above have played an important part in influencing physician supply and will continue to influence the supply and distribution of physicians in the future. The AMA believes that efforts must be made to coordinate all three levels of decision-making so that the best aspects of each is implemented.

Physician Manpower Policies Since the 1960s

During the 1960s and early 1970s, there was a consensus in both the government and the private sector that the U.S. physician population should be increased. This perception was based, in part, on a series of reports indicating a serious shortage of physicians in the U.S. and on the Medicare-Medicaid legislation of 1965-66 which was expected to increase greatly the public's demand for health care services. In response, federal legislation was passed and administrative regulations were developed to encourage the growth of the physician population. These actions included:

- the Health Professions Educational Assistance Act of 1963, which provided construction funds to expand the size and number of medical schools;
- the Health Manpower Act of 1968, which provided loans and scholarships to medical students and additional funds for construction of medical school facilities and operation costs; and
- a statement by the Department of Labor in 1965 that there was a physician shortage, thus giving preferred status to alien physicians wishing to immigrate to the U.S.

These actions were extremely effective. Between 1965 and 1975, the number of U.S. medical schools increased from 88 to 114 and the number of first-year medical students rose from 8,759 to 15,351.

In the middle 1970s, the general perception of a physician shortage began to fade. In 1976, Congress passed P.L. 94-484, which severely restricted the flow of alien foreign medical graduates into the U.S. Already at that time, many people were concerned about the possibility that the U.S. was training more physicians than needed. GMENAC was formed to determine how many physicians were required to bring supply into balance with the nation's needs for physician services. During the late 1970s, the federal government stopped providing capitation payments to medical schools, thereby eliminating incentives to maintain large enrollments. In 1980, GMENAC completed its Final Report, which projected a surplus of 70,000 physicians by 1990. Moreover, in the early 1980s further restrictions were placed on the entry of alien foreign medical graduates into residency programs.

The general perception of a physician shortage during the 1960s was the basis of manpower legislation which created programs to increase physician supply. The AMA believes that this legislation, a reaction to a perceived problem, became the vehicle by which more physicians have been and are now being trained than can be efficiently or effectively accommodated by the U.S. health care system. Thus, the continued rapid growth in physician supply is a result of the past overreaction to a perceived physician shortage.

It is imperative that current policy-makers heed the lessons of the past. Physician manpower policies which are incorrectly formulated will be a major source of problems in the health care system 20 years hence. Care must be taken to develop policies that will not inadvertently limit the chances of certain groups entering the physician population. The AMA is particularly sensitive to the situation of blacks and other minorities who are still underrepresented in U.S. medical schools. The high cost of medical education and the growing competition in the health care system may further reduce the entry of these groups into the medical education system.

III. CONCLUSIONS

There is no generally accepted single standard by which to measure the adequacy of physician supply. In the absence of such a standard, physician manpower policies must be based on the perceptions and professional judgment of policy makers together with the best available data and research on this complex issue. The analyses by GMENAC and a recent report by the Bureau of Health Professions indicate the projected supply of physicians will exceed requirements in 1990.

The AMA's research on supply adds credence to the projections on the growth in numbers of physicians. The state of knowledge on the demand or requirement side is weaker. The Association has underway a research program designed to examine these issues. The available data for the nation as a whole suggests that oversupply or surplus is much more likely than undersupply. Physician mobility across specialty groups and geographic borders significantly complicates specialty or area-specific analyses. The Association is concerned that imbalances of whatever kind can adversely affect the health of the American people.

Market forces cannot be relied on to adjust the growth rate of the U.S. physician population because the U.S. health care system does not operate in a free market. While the short-term growth of the physician population is unavoidable (due to the large number of medical students and residents already in the medical education pipeline), we are convinced that the negative consequences of long-term growth must be minimized.

Accordingly we believe that certain initial steps should be taken:

A. The U.S. medical education system should be encouraged to review data and analyses regarding physician supply and its impact on the quality and cost of care so that educators can appropriately establish the size of total enrollment. This could be accomplished by the following actions:

- Participation of all sectors of the U.S. medical education system in the planning and decision-making that will determine the size of the physician manpower pool in the future.
- Careful review by U.S. medical schools of the size of their current first-year enrollment. Decreases in student enrollments should not lead to decreased funding, if the quality of medical education programs is to be maintained.

If reductions in educational and training capacity are to be imposed on the medical education system, these reductions should begin with the first-year of medical school. Reductions in graduate medical education should not be made until the output of U.S. medical schools is reduced. Otherwise, U.S. medical school graduates may be unable to find funded residency slots to complete their medical training.

B. The current level of funding for medical education should be maintained despite potential decreases in student enrollments if the current quality of medical education is to be maintained. At the present time, many medical schools are not adequately funded. If future levels of funding are dependent on class size, many medical schools would be forced to maintain existing enrollments in order to remain financially sound.

Furthermore, a reduction in funding could jeopardize the research activities of medical schools.

C. Federal legislation and regulations that mandate maintaining specified enrollment in U.S. medical schools should be repealed. We also advocate the repeal of any state laws mandating maintenance of specified enrollments at state-supported medical schools. These actions would provide a clear expression of public policy that a medical school should not be penalized financially if a determination is made that it should reduce enrollment in order to ensure an appropriate level of quality in its educational program.

D. The enrollment in U.S. medical schools of blacks and other underrepresented groups should be supported. In any reduction process, their continued enrollment should be encouraged.

E. Appropriate quality standards and criteria for the practice of medicine must be promoted. Accreditation criteria must always be based soley on reasonable quality standards and may not be used for any other purposes. Where concerns about quality are documented, accrediting bodies have an obligation to take corrective action, regardless of the secondary effects. Thus the accreditation of foreign medical schools by the LCME or some other body in the private sector should be considered. In addition, residency program directors should be encouraged to thoroughly screen the credentials of all applicants for residency positions to ensure that they have had sufficient preparatory education. Finally, we advocate the continued development of more effective state licensing and disciplinary criteria.

This statement responds to many of the Council's specific questions. AMA's ongoing manpower research program will continue to address the many open issues on physician manpower policy.

The AMA commends COGME for holding this hearing and appreciates the opportunity to testify. We urge that each COGME subcommittee hold a hearing before making final recommendations.

Mr. Chairman, I will be happy to answer any questions members of the Council may have.

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Testimony of the Medical Society of the State of New York
Before the Council on Graduate Medical Education
Department of Health and Human Services, Health Resources and Services Administration

Delivered on November 19, 1987 at Bethesda, Maryland

Distinguished members of the Council, on behalf of the Medical Society of the State of New York, I would like to express our appreciation for this opportunity to address you concerning some of the critical issues relating to the graduate medical education system in the United States.

My name is Dr. David Benford and I am the Vice-President of the Medical Society of the State of New York. I also serve as the President of the Empire State Medical, Scientific and Educational Foundation, which is the the Peer Review Organization for Medicare in New York State.

Although this hearing is primarily aimed at exploring the national dimensions of the graduate medical education system, we believe that recent developments in New York State provide an excellent example of the potential dangers which can arise if graduate medical education is approached on a state by state basis, and we felt therefor that these developments should be brought to this Council's attention.

In 1984 the Governor of New York State directed the Commissioner of Health to establish a Commission on Graduate Medical Education (GME). This Commission was chaired by Alfred Gellhorn, M.D. and has become informally known as the "Gellhorn Commission". As part of its work, the Gellhorn Commission was charged with reviewing and making recommendations on some thirteen issues of "particular concern", such as:

"1. The appropriate number and types of post-graduate residency and fellowship positions for New York State;

2. An evaluation of New York State's graduate medical education programs as a national resource;

3. The impact of graduate medical education on health care costs;

4. The responsibility of, and opportunity for, graduate medical education to assist in meeting the needs of medically underserved populations in the State, and priority needs of State institutions and facilities;

5. The relationship between the number of graduate medical education positions and the undergraduate medical school class size in the State;

6. The responsibility of, and opportunity for, graduate medical education to increase the proportion of minority physicians practicing in the State;

7. The identification of incentives for increasing the emphasis on alternatives to inpatient care in post-graduate medical education;

8. The role of public and private academic medical centers in meeting State health and medical needs;

9. The protection of hospital patients from poorly educated and poorly trained residents and fellows;

10. The development of means for influencing the supply and distribution of specialists to fulfill defined social needs of the State, including use of the State's reimbursement process, grants and contracts, and the regulatory process;

11. The reduction of State support to graduate medical education in specialties where an oversupply already exists and the determination of the obstacles to reducing duplicative tertiary care services;

12. The evaluation of the effect of a substitution of physician extenders and other health personnel for residents;

13. The development of a mechanism for long-range graduate education planning."

The above need to be addressed, but the Medical Society of the State of New York would not agree with some of the methods recommended by the Gellhorn Commission to resolve them.

In February 1986, the Gellhorn Commission completed its work and published its report* which contained numerous "recommendations for changes" that the Commission "deemed advisable" in order to improve the operation of the graduate medical education system in New York State. The Medical Society of the State of New York reviewed this report carefully and was shocked and dismayed at some of its more controversial recommendations.

Perhaps the most objectionable part of the Gellhorn Commission Report was not any one particular recommendation but rather the extent to which the Commission would centralize authority for the administration of graduate medical education programs (including control of the funding mechanisms) in a state agency, namely the New York State Department of Health and to a lesser extent, the New York State Department of Education.

The graduate medical education system in New York, as envisioned by the Gellhorn Commission, would ostensibly be governed by regional consortia, composed of a medical school, the major regional teaching center and the affiliated hospitals in the region. In reality, however, the Commissioner of Health would have the ultimate authority over the operation of the system as he would control the distribution of graduate medical education funds and this "power of the purse" would almost automatically guarantee control of the system.

Funding for graduate medical education under the Gellhorn Commission Report would be accomplished through a pooling of the graduate medical education component now included in payments made by third party payers.

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*Report of the New York State Commission on Graduate Medical Education February 1986

Even graduate medical education payments made by Medicare would be included in this pool if the appropriate federal waivers could be obtained. Although the Gellhorn Report itself fails to specify who will actually control these pooled funds, legislation proposed by the New York State Department of Health, which would implement the findings of the Gellhorn Commission, makes it clear that the Commissioner of Health will ultimately determine which programs receive funding and which do not. Under the proposed legislation, funding would only be provided to those programs which meet preset and often reduced targets for, among other things, the number of residency positions in each area, the distribution of physicians by specialty, and the degree to which residents are replaced with salaried physicians and physician extenders.

Thus the effect of the Gellhorn Report and its companion implementing legislation would be to allow the State of New York to establish total control of the GME system by having the New York State Department of Health (DOH) and to a lesser extent the Department of Education (DOE) enter the domain of accreditation and funding of educational programs. The Medical Society of the State of New York believes strongly that such concentrated control of graduate medical education by an individual state agency is inappropriate and clearly not in the best interests of the medical education system or the people of New York State. The Medical Society of the State of New York has repeatedly opposed the introduction of a State system for the regulation of graduate medical education. It holds the view that the current system of accrediting residency programs has proven to be effective in assuring the maintenance of top quality residency programs both in New York State and throughout the country. We do not believe that a patchwork quilt of individual state regulations can properly take into consideration the legitimate national and state interests in preserving a uniform and open graduate medical education system.

It is interesting to note that the Gellhorn Commission also proposes to invest the state's plan with an air of objectivity and balance through the creation of a Council on GME composed of external consultants acting as an "advisory group" to the New York State Departments of Health and Education. The members of the Council have been appointed by the Commissioners of those very same Departments. This certainly would compromise the Council's objectivity in evaluating and recommending changes in the graduate medical education system.

In our view the Gellhorn Commission Report, which is receiving serious consideration in New York State, failed to recognize that a national system for standard-setting and review of performance and accreditation of graduate medical education is already in existence. In fact, the only concession made by the Commission to the importance of maintaining a national standard is a recommendation that the standards of the national accrediting bodies be met along with any additional standards developed by New York State. The graduate medical education system in New York State could therefore be complicated and even compromised by the adoption of additional standards recommended by the new allegedly "independent" Council. Failure to meet one of these new standards could lead, in effect, to State disaccreditation of a hospital's nationally approved residency training program. Furthermore, in the event that the Department of Health were to obtain control over the distribution of graduate medical education funds to hospitals, the hospitals would be virtually forced to comply with even clearly inappropriate rules in order to assure that the State release the needed funds.

Aside from the issue of centralized authority in the Department of Health, the Gellhorn Commission also made several substantive recommendations which we believe are worthy of comment. One recommendation was to reduce the number of residency slots in New York State to approximate the number of medical students graduating from New York medical schools each year. This would result in a reduction of approximately 30% of the present residency positions. Aside from potential hospital manpower problems which this recommendation might trigger it also fails to recognize New York State's unique national position in the training of our nation's physicians. The Medical Society of the State of New York is justifiably proud of the caliber of the residency training programs in our state and we see no need to alter the system by arbitrarily linking the number of training opportunities in New York to the number of New York medical school graduates.

The Gellhorn Commission Report also recommended that the proportion of residents who are training in New York who are graduates of foreign medical schools should be reduced within five years time from the present average statewide level of [illegible] to not more than 10%. (Waivers may be permitted in exceptional circumstances.)

This proposed across the board cut fails to consider the fact that New York State foreign medical graduates play an essential role in staffing those hospitals that care for the poor and the mentally ill. Foreign medical graduates serve as residents in a much higher proportion than graduates of U.S. medical schools in these hospitals. No adequate plan to substitute for foreign medical graduates as residents in these hospitals has been put forward.

We would also note that even if the plan proposed by the Gellhorn Commission were rationally conceived, it seems foolish for the State to run ahead of the Federal Government in devising restrictive formulas for controlling the entry of foreign medical graduates at a time when the subject is on the Congressional agenda. This issue is a national issue and thus is most amenable to a national approach.

Another critical recommendation of the Gellhorn Commission is a proposal to radically slash the amount of funds available for medical and pediatric subspecialty training programs in New York State and redirect those funds to primary care physician training. While an increase in the number of primary care physicians may indeed be a good idea, we believe that the proposed approach is extremely shortsighted. Prospective physicians should be able to choose their field of practice without undue governmental intrusion. Furthermore we feel that market considerations, coupled with prudent but not arbitrary governmental decision making on a national level can best assure the optimum mix of residency positions. Permitting state governmental intrusion in this area would be both inadvisable and ineffective.

No greater example of the danger of a state by state provincial approach to residency training can be found than in the New York State Plan for Graduate Medical Education. Under the proposed plan, funding for residents in medicine and pediatrics would be strictly limited to the three year period required for the initial eligibility for American Board Certification. Present support of subspecialty training in New York State would generally be discontinued and the present excellent programs for such training would disappear. The Medical Society of the State of New York believes that such a result would be extremely undesirable and could even result in a shortage of specialists in certain areas. The Medical Society of the State of New York further believes that a coordinated national approach is essential to assure the availability of both primary care physicians and specialists and that attempts by any individual state to arbitrarily limit specialty training would be counterproductive. Furthermore, it is difficult to reconcile the Gellhorn Commission's acceptance of discrepant funding periods for medicine and surgery, especially the much longer period of contemplated payment for surgical residencies, with the Commission's other recommendations. It appears to be internally inconsistent with the general thrust of the Commission recommendations, i.e. to reduce specialization and increase primary care residency positions.

It also appears that several of the premises apparently relied on by the Gellhorn Commission in this area are flawed in that they seem to assume that only primary care physicians are in short supply and that physician surpluses are found primarily in the medical subspecialty area. To the contrary, according to the study of the Graduate Medical Education Advisory

Committee (GMENAC), general surgery is projected to have the greatest surplus of any specialty yet the Gellhorn Commission recommends no decrease in funding. Conversely, Hematology/Oncology, a medical subspecialty, is expected to have a considerable shortage. It is also noteworthy that the Gellhorn Commission clings to the belief that only primary care residencies are worthy of funding. The funding for specialty fellowships in geriatrics would also be a casualty, an area where trained physicians are clearly essential as our population ages.

I have attempted during my testimony to point out what the Medical Society of the State of New York sees as the flaws inherent in both the concept of individual state regulation of graduate medical education as well as the specific problems with the approach advocated for New York State by the Gellhorn Commission. The Medical Society of the State of New York believes that our state should remain a resource for high quality training of medical graduates, not only for the state, but also for the nation as a whole. We believe strongly that any change in the current system of graduate medical education funding and operation should only be considered in the context of a national approach to the issue after a thorough and unbiased investigation of the many complex issues involved. We stand ready to assist you in any way we can in that ongoing investigation. Once again, I wish to thank you for allowing us the opportunity to testify today.

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

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November 19, 1987

COMPARISON OF THE FMGEMS AND THE NBME PART I AND PART II EXAMINATIONS
JOINT STATEMENT BY ECFMG AND NBME

The Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) is an examination developed cooperatively by the Educational Commission for Foreign Medical Graduates (ECFMG) and the National Board of Medical Examiners (NBME) to assess knowledge in the basic medical and clinical sciences. Graduates of foreign medical schools (regardless of citizenship) are required to pass FMGEMS to satisfy the medical science examination requirement for ECFMG certification.

ECFMG certification provides assurance to directors of ACGME-accredited programs and to the people of the United States that graduates of foreign medical schools have met minimum standards of eligibility required to enter such programs. ECFMG certification is also a prerequisite for licensure to practice medicine in most states in the United States.

For alien physicians to obtain visas to enter the United States to perform services as members of the medical profession or to receive graduate medical education, as required under provisions of the Immigration and Nationality Act (Public Law 94-484) they must pass the NBME Part I and Part II examinations or an examination determined to be equivalent. The Secretary of Health and Human Services has recognized FMGEMS as equivalent to the NBME Part I and II examinations for this purpose.

During the construction phase of FMGEMS, items (questions) from the NBME pool of test questions are identified for possible inclusion in FMGEMS. All of the items selected for inclusion in FMGEMS have been used in recent NBME Part I and Part II examinations and must meet a number of content and measurement requirements.

With respect to content, 70 items are selected from each of the seven basic medical science subjects for inclusion in Day 1 of FMGEMS and 75 from each of the six clinical science subjects for inclusion in Day 2 of FMGEMS. This parallels the proportional representation of these same subjects in the NBME Part I and Part II examinations. For example, there are approximately 150 items in each of the clinical science subjects of NBME Part II; since FMGEMS is half the length of the Part II examination, there are 75 items from each of these subjects in Day 2 of FMGEMS.

In addition, the items from each of the content categories within each basic medical science and clinical science subject are selected proportionately based upon the content category allocations currently used in the construction of the NBME Part I and Part II examinations. For example, all the categories within the biochemistry subject on NBME Part I are represented in the same proportion on the FMGEMS examination. This is done for all of the subjects so that FMGEMS, although half the length of the NBME Part I and II examinations, is comparable in terms of content.

With respect to measurement characteristics of FMGEMS, item statistics are available for all items in the NBME test item pool based on the performance of students and graduates from LCME accredited schools who answered these questions on the NBME Part I and Part II. The item statistics of interest are item difficulty (how easy or hard the item was to answer correctly by examinees) and test-item correlation (data indicating how well individual items relate to the overall examination). Using these data, test items are selected for the subjects in FMGEMS that are equal in average difficult and average test-item correlations to those same subjects on NBME Part I and II examinations. In addition to these average values, the ranges of item difficulty and ranges of test-item correlation are matched against the ranges for these same data from the NBME examinations. This effort assures that FMGEMS is comparable in terms of difficulty and test-item correlations to recent NBME Part I and II examinations.

Since there are four different types of item formats within the NBME item pool, consideration is also given to the format of items selected for FMGEMS. The items selected for FMGEMS are matched in terms of this characteristic against the NBME Part I and Part II examinations. This step provides assurance that approximately the same proportion of each of the item types that appear in the NBME examinations also appear in FMGEMS, including a reasonably close match in the number of items related to pictorial material.

As part of a final step, the examination is reviewed sequentially by two committees. The first, appointed by ECFMG, is composed of medical educators representing the 13 disciplines of the Day 1 and Day 2 components of FMGEMS. The ECFMG test committee is instructed to examine FMGEMS for overemphasis, underemphasis or duplication in content, to check for scientific accuracy and clarity and otherwise to assure that the examination is acceptable for ECFMG certification. Any items removed based upon this review are replaced with items acceptable to the committee that are similar in all of the content and measurement characteristics noted above.

The second committee, brought together by NBME, is made up of the chairmen of the thirteen NBME Basic Medical Sciences and Clinical Sciences Committees. This committee reviews FMGEMS for scientific accuracy and clarity, assures that the items are current and that the overall FMGEMS is representative of the longer NBME Part I and Part II examinations. Any items removed based upon this review are replaced with items acceptable to the committee that are similar in all of the content and measurement characteristics noted above.

During the scoring phase of the FMGEMS testing process special steps are taken to assure the comparability of FMGEMS and the NBME examinations. Each item in FMGEMS is derived from the NBME pool of test items and is described by statistics which reflect the test item performance when used in NBME Part I and Part II examinations. Item difficulty data are used to calculate scores on FMGEMS that would be expected if a recent NBME Part I or Part II group had taken, in a single administration, the same combination of items that is on FMGEMS. Using these scores, the NBME Part I and Part II minimum pass scores are applied to the Day 1 and Day 2 parts of FMGEMS.

For Day 1 of FMGEMS and NBME Part I, the minimum pass point typically requires that examinees answer between 55% and 60% of the Basic Science items correctly to pass. For Day 2 of FMGEMS and NBME Part II the percent correct range that corresponds to the minimum pass level is usually between 50% and 55%.

This summary of FMGEMS test construction and scoring provides a general understanding of the steps taken to assure the comparability of the FMGEMS and NBME test and the collaborative efforts by ECFMG and NBME in FMGEMS construction. These procedures are intended to meet the requirements for ECFMG Certification and Public Law 94-484 in a fair and reasonable manner by using recognized test construction and scoring procedures.

ABMAC

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STATEMENT BY ABMAC TO COGME
NOVEMBER 18, 1987

Mr. Chairman and Committee Members

I am Dr. H. William Harris, Director of the Bellevue Hospital Chest Service, and Professof of Clinical Medicine of the New York University Medical Center. I am grateful for this opportunity to address you briefly on behalf of ABMAC, the American Bureau for Medical Advancement in China. Dr. Richard Pierson, President of ABMAC, regretably could not come to Washington today, and asked me, as president elect, to present ABMAC's reaction to your important agenda, especially the part relating to the training of foreign medical graduates.

ABMAC was founded in NYC in 1937 as a voluntary effort to obtain much needed medical equipment and supplies in the U.S. and furnish these to the medically destitute Chinese military and civilian population during the SinoJapanese war. ABMAC fulfilled this purpose to a remarkable extent in light of the funds available at that time. In 1949, ABMAC removed its activities from mainland China, and relocated attention so as to help meet the enormous health needs in Taiwan. At first, assistance was principly in the form of money, equipment and supplies donated by interested and caring citizens in the U.S. However, after crisis conditions abated there and, working collaboratively over three decades with medical and nursing schools, teaching hospitals, and public health agencies in Taiwan, ABMAC has directed a major effort to assisting young physicians, nurses, medical scientists, public health workers, and other health-related professionals in Taiwan obtain appointments for appropriate post graduate training in the leading academic centers in the U.S. More than 400 ABMAC fellows have been trained in leading teaching hospitals, medical schools, and research laboratories throughout the United States. Most have spent a minimum of one year, and a few up to three years pursuing specialty and subspecialty training. Every one of these 400 trainees, with only two exceptions known, have returned to Taiwan on completing their training; today they are in positions of leadership in Taiwan's major medical schools, hospitals, and official health agencies.

We in ABMAC take great pride in our accomplishments in this role; we believe that our long experience might assist you with the formidable task of constructing future plans for graduate medical training in the U.S.

.../...

ABMAC is a non-profit, non-political, medical and scientific organization dedicated to the advancement of health in the Republic of China

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Please permit me to outline what we believe to be the essential components of this successful program.

1. Candidates for American training are nominated for ABMAC fellowships by responsible officials and staff of a Taiwan sponsoring institution.

2. Both the candidate and sponsoring institution must define in writing the specific goals sought from the training experience in the United States.

3. The Taiwan sponsoring institution must assume total responsibility for salary and travel expense of the trainee. ABMAC acts as a dispersing agent for the Taiwan institution while the trainee is in the U.S.

4. As a pre-requisite to appointment as an ABMAC fellow, the candidate must be interviewed by an ABMAC executive in Taiwan in order to insure the candidate's serious purpose, commitment to learning, and adequate English skills.

5. The candidate must be furnished a contract by the Taiwan sponsoring institution that guarantees an appropriate salaried post in that institution on completion of the training. The trainee must sign a contract agreeing to return to the sponsoring institution in Taiwan and occupy the post cited. An ABMAC official must certify the existence of both contracts.

6. After the candidate is nominated as an ABMAC fellow, members of ABMAC's fellowship committee, and others on the Board of Directors, either directly or with the assistance of professional colleagues, seek openings for the ABMAC fellow in the leading U.S. medical institutions; the committee identifies and recommends the best possible available appointment to satisfy the fellow's specific goals.

Our success rate has been high because U.S. teaching institutions can be assured that the ABMAC fellow has been rigorously evaluated, has adequate language skills, and will assuredly return to his own country, and contribute there the knowledge and skills acquired in the U.S.

Many deans, clinical and basic science department and division heads, and research scientists in Taiwan's medical schools and teaching hospitals have had training in the U.S., many as ABMAC fellows. Today, they can arrange placement of young physicians and investigators in U.S. training programs directly. Thus, the academic institutions in Taiwan have less need for ABMAC's fellowship assistance than in the past. However, Taiwan National and Provincial governmental agencies are developing a network of health facilities throughout the island that will functionally connect provincial clinics and village hospitals with secondary and tertiary hosptials in the larger cities. Health officials there have identified a continuing need for ABM[illegible]'s assistance in providing suitable post graduate training opportunities i[illegible] U.S. for the primary physicians, specialty nurses and other health wor[illegible] needed for this country-wide expanded health program. American graduate [illegible]ning is still needed in diverse fields of public health, preventive medicine, environmental pollution, industrial hygiene, geriatrics and many other health related areas.

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For obvious reasons, ABMAC is especially interested in the work of your subcommittee on Foreign Medical Graduates; we are vitally concerned with the question "Should the United States continue to provide specialty training for international exchange visitors who will return to their native countries to practice?" We firmly endorse the conclusion 3.2 and 3.3 of this subcommittee indicating that there is a need to expand and modify educational opportunities in the U.S. for exchange visitor physicians to better meet health care needs of their home country, and that U.S. relations with foreign countries will be harmed if such educational opportunities are curtailed. We also agree and support the recommendations of this subcommittee cited under Items 3, 4 and 5.

In light of the tremendous need for better health in underdeveloped countries throughout the world, a question every citizen should ponder is "How can we best use American experience, skills, and competence to provide better health for less fortunate people in underdeveloped areas of the world?" Possibly ABMAC's programs supporting better health in Taiwan during the past 38 years may contain elements that could model health alliances between the world's less developed countries and the U.S.

Today, health conditions in some underdeveloped countries are comparable to circumstances in Taiwan in the 1950's. In that period, ABMAC helped Taiwan develop improved national programs of public health and medical care. Possibly ABMAC's techniques and experience there could provide guidance to other voluntary and official agencies interested in improving health in underdeveloped countries today. We believe that such agencies could have similar impact in underdeveloped countries provided sufficient safeguards are established to insure that the American training acquired by their medical graduates is appropriate for a future role in the native country, and that the alternative of remaining in the United States after training does not exist. A beginning could be made by stricter requirements for training that is appropriate and not principally intern-type medical service provided by the FMG for an American medical institution.

Our ability to educate FMG's appropriately might benefit by the development of an overseeing organization, such as a council, with responsibility and authority to match the skills needed in countries sending training candidates here with the programs best equipped for that specific purpose among American medical institutions. Based on a roster of cooperating U.S. medical institutions, a type of placement service for FMG's could be developed. A council, however, should be firmly attached to voluntary and academic institutions, as well as government agencies. Although enforcement processes are required for effective function of such a council, we believe that fellowship programs should be operated primarily by academic institutions and voluntary agencies, such as ABMAC. In order to maintain the flexibility necessary for such a program, we believe it essential that a quota limiting the total complement of physicians training in the U.S. must be avoided. One would hope that improved organization overall, might reestablish the original intent of US based FMG training programs, that is the improvement of health and quality of human life worldwide.

May I thank you, Mr. Chairman, for this opportunity to acquaint you with the American Bureau for Medical Advancement in China, and to describe our past and present role in training Chinese post graduate students in the United States.

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INTERAMERICAN COLLEGE OF PHYSICIANS AND SURGEONS

"Apretón de Manos Curativas"

Building an Interamerican Community of Physicians

November 1987

INTERAMERICAN COLLEGE OF PHYSICIANS AND SURGEONS

Background Information

Purpose

The Interamerican College of Physicians and Surgeons(ICPS) is a non-profit, tax-exempt, nongovernmental organization incorporated in the District of Columbia as an educational, charitable, medical corporation. It is governed by an eight-member Board of Regents, presided over by a chairman. Articles of Incorporation were filed on Februrary 23, 1979.

ICPS was created to promote greater communication and cooperation among Hispanic physicians practicing in the U.S. and Latin America. It is a vehicle that foments a professional network among the physicians of the Americas and Spain and serves to develop and stimulate friendship and cooperation among physicians throughout the Americas by harnessing their talents, resources, and goodwill for the betterment of society.

Objectives

The objectives of the Interamerican College of Physicians and Surgeons are far-reaching in scope:

To increase understanding and medical communication in its broadest sense among the physicians of the Americas

To focus developing health resources to meet the functional and educational needs of ICPS Fellows and physicians in general

To develop a network of communication reaching medical schools, medical societies, governmental agencies, and individual physicians, so as to enrich and enhance health care, economic growth and cooperation throughout the Americas

To strengthen new cooperative health ventures and stimulate new interest in programs that are already in existence

Publications

The official publication of the College is **MEDICO** Interamericano magazine. It is the only Spanish-language medical journal in the U.S., and is distributed monthly, free of charge, to over 25,000 Hispanic physicians residing in the U.S and Puerto Rico. In September of 1987, ICPS launched **Buena Salud**, a health-oriented magazine in Spanish, aimed at the general Hispanic audience of the U.S. It is filling a void in the area of health information available to patients in Spanish.

Fellowships

Fellowships in the College are available to distinguished physicians practicing in the United States, Mexico, the Caribbean, Central and South America, and Spain. Some distinguished College Fellows include: Severo Ochoa, M.D., Nobel Prize in Medicine (1959); César Milstein, M.D., Nobel Prize in Medicine (1984); Jaime Lusinchi, M.D., President of the Republic of Venezuela; Major General Enrique Méndez, Jr., M.D., Dean of the School of Medicine, Ponce, Puerto Rico.

"APRETON DE MANOS CURATIVAS"

Purpose

In its efforts to build a bridge of technical knowledge and human understanding, in September of 1985, the Interamerican College of Physicians and Surgeons (ICPS), in cooperation with the Latin American Bureau of the Agency for International Development (AID), created a physician-to-physician exchange program throughout the inter-American medical community, "Apreton de Manos Curativas".

The purpose of the ICPS/USAID Cooperative Agreement is to design and implement a medical technology exchange program between members of ICPS practicing primary care medicine in the U.S. and physicians in South America, Central America, the Caribbean and Mexico.

ICPS is uniquely prepared to facilitate technical training exchanges both in the U.S. and in Latin America because its membership is characterized by bilingual individuals who are aware of the culture, customs and behavior of the inhabitants of the Americas.

Many ICPS members are directly involved in the training of medical students and the delivery of primary care services to underserved populations in the U.S. This is why some of the training for the exchange physicians takes place in the states with the largest Hispanic populations.

ICPS views the Physician Exchange Program as an opportunity to develop health care leadership in the U.S. and in the LAC/countries as a hemispheric resource.

Funding

The Agency for International Development gave funding to ICPS, to develop and implement a four year (1985 - 1989) pilot physicians exchange program called, "Apretón de Manos Curativas."

Costs Covered by Scholarship

The short-term scholarships offered include the following:

1. Round Trip Airfare (coach) from country of origin

2. Travel Within the U.S. and Puerto Rico to cities involved in the training plan

3. Per Diem/Monthly Allowance to cover housing accomodations, food, in-city transportation and incidentals.

4. Book Allowance: for 6 months of training, participant will receive $65 per month for books. If training is less than 6 months, participant will receive $60 total for books

5. Shipment of Books: books will be shipped to the trainee's home country at the end of his/her training period, maximum of 60 lbs.

6. Health Insurance and Accident Coverage: $40 per month for the duration of the training. Medical exam required prior to acceptance. No previously existing medical conditions will be covered. Emergency dental care is covered.

7. ICPS Membership: As part of the follow-up, the cost of ICPS professional membership will be paid for the first year following the training

Certificates

Each participant will receive a certificate upon completion of the training and a letter of certification from ICPS

How to Apply for an ICPS/USAID Scholarship

Physicians in Latin America, interested in applying for a scholarship, may do so by contacting the AID Mission at the American Embassy in their country

Phase I

Phase I of the project is designed to bring exchange physicians from Latin America to train in the U.S.(from one to six months), and includes the following activities:

o The placement of LAC/Physicians with Spanish-speaking primary care practitioners in rural and urban areas, to observe and participate, where possible, in the delivery of medical services.

- The design and conduct of informal/formal structured training programs supervised by ICPS physician preceptors. Both clinical and non-clinical skills are incorporated into the preceptorship program which include: Pediatrics, Obstetrics and Gynecology Family Medicine, Emergency Medicine, Opthamology, Rehabilitation Medicine, Hospital Administration and Public Health.

- Placement of physicians in innovative service delivery environments wherever possible.

- ICPS serves USAID Mission requests for information and guidance on clinical training in the United States.

During its first year (1986) "Apretón de Manos Curativas" brought 10 trainees from the following countries: Mexico, El Salvador, Guatemala, the Dominican Republic and Ecuador. The specialties of the exchange physicians were: Hospital Administration, Pediatrics, Public Health Administration, HMO Management Observation/Emergency Medical Systems, Rehabilitation Medicine.

In 1987, the project brought 12 Latin American physicians. The first group of 8 arrived on June 28th, and the second group of 4 on October 18th. The countries receiving scholarships were: Honduras, Costa Rica, Bolivia, and Guatemala (for the first group) and Colombia and El Salvador (for the second group). The specialties of the first group were: Pediatrics, Family Medicine, OB-GYN, Emergency Medicine and Hospital Administration. The specialties of the second group were Emergency Medicine, Traumatology and Hospital Administration.

Phase II

Phase II of the project sends U.S. physicians (mostly Hispanic) to Latin America and the Caribbean to provide short-term technical assistance. The request for this type of assistance must come from the AID Mission at the American Embassy in the country in question.

In 1987, the Salvadoran Rehabilitation Institute requested technical assistance from the AID Mission in El Salvador. "Apretón de Manos Curativas" was asked to send two Hispanic physicians (one with a background in Hospital Administration, and the other, an orthopedic surgeon with a background in physiatry and rehabilitation) as part of a four-man team, to do a comprehensive evaluation of the Center for Locomotor Devices, in terms of medical services, protheses, physical therapy, occupational therapy and administration of the center.

Volunteerism

"Apretón de Manos Curativas" is made possible through the volunteer efforts of a network of Spanish-speaking physicians throughout the United States and Puerto Rico. These preceptors freely share their time, knowledge and experience with the exchange physicians so that when these trainees return home they can translate/adapt the knowledge and experience that they have gained during their training in the United States and apply it to their national/local needs.

Preceptors aid in the progress of Latin America, in the health field, with their contribution. For many Hispanic physicians, living in the U.S., this project offers an opportunity to contribute, in a personal way, to the growth and development of the Latin American health care delivery system.

For Further Information

If you would like additional information or would like to serve as a preceptor, please write or call:

Luis Patiño
Director
ICPS: Physicians Exchange Programs
515 22nd St., N.W. Suite 60
Washington, D.C. 20037
(202) 223-3607

INTERAMERICAN COLLEGE OF PHYSICIANS AND SURGEONS

POSITION ON FOREIGN MEDICAL GRADUATES

Presented at the
November 19 - 20, 1987 Public Hearing
of the Council on Graduate Medical Education (COGME)
Washington, D.C.

POSITION 1:

THE CURRENT GME SYSTEM SHOULD CONTINUE TO BE USED FOR POST-GRADUATE EDUCATION OF EXCHANGE VISITOR PHYSICIANS. THE RESIDENCY PROGRAMS SHOULD BE ENCOURAGED TO PROVIDE RELEVANT, TAILORED POSTGRADUATE EDUCATIONAL EXPERIENCES FOR EXCHANGE VISITOR PHYSICIANS WITH EMPHASIS ON SATISFYING HOME COUNTRY NEEDS.

POSITION 2:

EXCHANGE VISITOR EDUCATION EXPERIENCES SHOULD NOT BE CONFINED TO MEDICAL SCHOOL AFFILIATED PROGRAMS. OPPORTUNITIES SHOULD INCLUDE PROGRAMS OFFERED BY PRIVATE ORGANIZATIONS AND PROGRAMS UTILIZING STRUCTURED PRECEPTORSHIP EXPERIENCES.

POSITION 3:

THE U.S. SHOULD CONSIDER THE ORGANIZATION OF A "TRUE" INTERNATIONAL HEALTH SERVICE CORPS WHICH WOULD BE COMPOSED MAINLY OF U.S.- TRAINED EXCHANGE VISITOR PHYSICIANS.

POSITION 4:

THE CLINICAL SCREENING EXAM FOR EXCHANGE VISITOR PHYSICIANS SHOULD BE A TRUE TEST OF CLINICAL COMPETENCE.

POSITION 5:

THE UNITED STATES GOVERNMENT SHOULD FINANCE EXCHANGE PROGRAMS FOR PRACTICING PHYSICIANS FROM FOREIGN COUNTRIES TO STUDY IN THE U.S. SINCE THESE PROGRAMS ARE AN ARM OF U.S. FOREIGN POLICY AND SERVE TO REINFORCE U.S. POLICY OBJECTIVES AT HOME AND ABROAD.

INTERAMERICAN COLLEGE OF PHYSICIANS AND SURGEONS:

A POSITION PAPER ON FOREIGN MEDICAL GRADUATES

NOVEMBER 1987

Interamerican College of Physicians and Surgeons:
A Position Paper on Foreign Medical Graduates

Those searching for a foreign policy triumph should not overlook the golden opportunity which supporting intense and expanded international medical education and service exchange affords. International medical education exchange is a powerful instrument for fostering international harmony.

The current discussions concerning the appropriate method of funding graduate medical education should not be allowed to diminish or interfere with the use of graduate medical education as a valuable instrument for international medical exchange.

Although there is much room for improvement in graduate medical education, its continued participation in the U.S. effort to achieve international understanding should be appreciated and supported.

The role which GME has played in the U.S. health care system is complicated and extends far beyond medical education to the areas of medical service delivery and international medical exchange. The role foreign medical graduates have been asked to play in GME has a history which is closely linked to domestic physician manpower needs. To illustrate this pattern of foreign medical graduate utilization we need only review the driving forces responsible for the legislation and regulation associated with this group of health professionals.

DATE	LEGISLATION, REGULATIONS, ISSUES,	INTENTION, PROBLEMS
1948	Smith Mundt Act The U.S.	Establish true Exchange
1946-1950	Limited availability of undergraduate positions	Active recruitment of FMGs Congress expected 500 entrants per year
	Expanding residency positions to accomodate returning vets, associated with construction of new hospitals (Hill Burton Act)	
1950-1951		2000 exchange physician visitors entered
		Active conversion of visa status
1956	Smith Mundt Act Amended requiring	

	a 2 year return home prior to immigrant visa consideration	
1959	State Department limits residency training to 5 years for exchange visitors	loosely enforced
1953-1963		3,636 waivers permitting conversion were granted
1958	First ECFMG exam	
1965	Immigration Act of 1952 was amended	physician preference categories established
	Hospital-based care expanded via insurance (Medicare, Blues)	
1976	PL. 94-484 Title VI of Health Profession Educational Assistance Act of 1976	Limitation on use of J visa requiring: return home assurance total 2 year study period VQE Intention - limit entry, ensure return home, accomodate U.S. graduates
1976-1980	Substantial Disruption	to allow phasing out of FMGs in dependent hospital

(Legislative Cronology)

As this history clearly shows foreign medical graduate participation in GME has been an international affair which has served both the U.S. medical health care delivery system as well as foreign physicians in ways which deviated from the original intention of the Smith Mundt Act.

The current discussion cannot divorce itself from this history. The historic utilization of exchange visitor programs for preferential entry to immigrant status, though it was actively promoted by the U.S. and served U.S. needs, was an unfortunate misdirection of a program created to promote international sharing of medical knowledge and expertise.

The ICPS has been active in the area of international medical exchange and supports the utilization of GME in a modified form as an instrument of international policy. It proposes an alternative, expanded international medical education and service exchange model. The proposed modifications include: short-term preceptorship program; elimination of exam barriers to entry for selected accomplished clinicians to participate in U.S. GME; and the formation of a truly international organ of peace, an International Health Service Corps.

The ICPS position can be summarized as follows:

ISSUE:

Should the U.S. continue to use GME for international medical education exchange?

POSITION 1:

THE CURRENT GME SYSTEM SHOULD CONTINUE TO BE USED FOR POSTGRADUATE EDUCATION OF EXCHANGE VISITOR PHYSICIANS. THE RESIDENCY PROGRAMS SHOULD BE ENCOURAGED TO PROVIDE RELEVANT, TAILORED POSTGRADUATE EDUCATIONAL EXPERIENCES FOR EXCHANGE VISITOR PHYSICIANS WITH EMPHASIS ON SATISFYING HOME COUNTRY NEEDS.

RATIONALE:

We feel that the continued use of graduate medical education positions for international medical education exchange is appropriate however, important modifications would be required to make these experiences more relevant to the exchange visitor physician.

One of the major, and more significant, criticisms of the continued use of GME for exchange physician education has been that the skills acquired in the high-technology tertiary health care center of the U.S. cannot be easily transferred to the exchange physician's home setting. If GME continues its traditional emphasis on the development of nonprimary care expertise, the above argument is valid and difficult to counter. GME programs in the U.S. have recently been placing greater emphasis on primary and ambulatory care. The importance of this neglected area has been recognized by family medicine, general internal medicine and general pediatrics.

These disciplines have made major curricular changes in these areas. This new direction in GME makes these programs more relevant to the needs of exchange visitors who will be returning to the home country to practice primary care. The current increasing emphasis on abulatory care is a direct by-product of the appreciation of the importance of primary care training.

Although these educational innovations in primary care and ambulatory care may make our GME system more meaningful and relevant to exchange visitor physicians who may enter from less developed countries, there is still a need for greater flexibility within residency programs. Residency programs should be programed to tailor existing educational experiences to meet the specific needs of an individual exchange visitor physicians and the needs of their home countries.

ISSUE:

Should future exchange visitor physician training be limited to medical school affiliated programs?

POSITION 2:

EXCHANGE VISITOR EDUCATION EXPERIENCES SHOULD NOT BE CONFINED TO MEDICAL SCHOOL AFFILIATED PROGRAMS. OPPORTUNITIES SHOULD INCLUDE PROGRAMS OFFERED BY PRIVATE ORGANIZATIONS AND PROGRAMS UTILIZING STRUCTURED PRECEPTORSHIP EXPERIENCES.

RATIONALE:

Again the lessons of history tell us that medical schools have traditionally concentrated on expanding the body of knowledge in medicine and have established the reputation of being centers of excellence which have attracted more applicants than they could accomodate. This system offers many valuable experiences for exchange visitors and should continue to participate in this international exchange activity. There are, however, many advantages to considering alternate models which, though not linked to medical schools, can offer educational flexibility and learning opportunities which are currently not being provided in the high-tech medical school controlled programs. Exchange visitor physicians can often have a more meaningful educational experience in the ambulatory sector at the side of a seasoned professional mentor. In this setting they can observe the expert management of health care problems within the limitations found in the nontertiary setting. They can learn how practitioners avail themselves of community resources in the management of their more complicated cases. This type of training is more meaningful because it is more applicable and transferable than the intense exposure to organ-transplant surgery, nuclear medicine or other sophisticated high-tech marvels which are not available in the homeland.

ISSUE:

Should the U.S. health care system participate in a global medical service system?

POSITION 3:

THE U.S. SHOULD CONSIDER THE ORGANIZATION OF A "TRUE" INTERNATIONAL HEALTH SERVICE CORPS WHICH WOULD BE COMPOSED MAINLY OF U.S.-TRAINED EXCHANGE VISITOR PHYSICIANS.

RATIONALE:

The U.S., a recognized economic and political world leader, should also be the nation that leads the world to a new and exciting program of mutual assistance. We propose that the U.S. consider establishing a "true" International Health Service Corps. This global health corps could be composed primarily of exchange visitor physicians trained in the U.S. medical care system. The experience would allow them to share their American training with the developing nations. This would make the exchange visitor program more responsive to global health care service and educational needs.

ISSUE:

Is a screening exam appropriate and necessary for exchange visitors who are accomplished clinicians in order for them to participate in GME?

POSITION 4:

THE CLINICAL SCREENING EXAM FOR EXCHANGE VISITOR PHYSICIANS SHOULD BE A TRUE TEST OF CLINICAL COMPETENCE.

RATIONALE:

While the ICPS recognizes the need for some screening process which would ensure the American public is receiving health care at the hands of competent, well-prepared health professionals, it is not clear that the current process solely serves that purpose. Qualified, accomplished clinicians are often excluded from participation in U.S. graduate medical education because of certain current illogical regulations.

While the clinical science portion of the current FMGEMS exam is an appropriate measure of clinical competence, the basic science portion is not a valid measure of clinical decision-making expertise. Although we acknowledge the value of understanding basic scientific principles such as the Embden-Meyerhoff pathway and Krebs cycle, and their roles in carbohydrate metabolism, recall of the details of these biochemical pathways is not necessary for high-quality management of a comatose diabetic patient. Although basic sciences form the foundation of clinical practice, rarely do pratitioners need to recall such concepts in order to manage the problems which they encounter. Since the basic science portion of the exam does not truly measure clinical competence, it serves primarily as a barrier to the entry of older accomplished clinicians who wish to avail themselves of U.S. GME in order to improve their own practice and to return to their home and share their new knowledge with their countrymen.

In addition to the above arguments against the screening value of the basic science portion of the exam, there is also another important argument which questions the educational soundness of requiring applicants to GME, who supposedly come from countries which do not offer the high standard of medical training which is available in the U.S., to demonstrate that they have attained the same level of competency as graduates of U.S. medical schools.

ISSUE:

Who should finance physicians' exchange programs ?

POSITION 5:

THE UNITED STATES GOVERNMENT SHOULD FINANCE EXCHANGE PROGRAMS FOR PRACTICING PHYSICIANS FROM FOREIGN COUNTRIES TO STUDY IN THE U.S. SINCE THESE PROGRAMS ARE AN ARM OF U.S. FOREIGN POLICY AND SERVE TO REINFORCE U.S. POLICY OBJECTIVES AT HOME AND ABROAD.

RATIONALE:

There are several reasons the U.S. Government should lead the way in financing physicians exchange programs between the U.S. and foreign countries, particularly in the developing world. Since the passage of Public Law 94-484 (1976), which restricted access of physicians from foreign countries to study in the U.S. Some have perceived the U.S. attitude as disinterest in sharing the advances of modern medicine. Others perceive it as a lack of commitment to the future of international exchange of medical technology. In contrast, the Soviet Union and Eastern Bloc nations have increased their exchange and scholarship programs for foreign medical students dramatically in the last decade. The influence of the United States in the training of health care professionals is relatively small today compared to that of the Soviet Union.

The Department of State, including the Agency for International Development and USIA, while promoting other educational exchange programs, have not fully taken into consideration, the important role that U.S.- trained physicians play in in the foreign and national policy making in their own countries. Many of them hold leadership positions, and promote the use of U.S. technology, which enhances the commercial relations between the U.S. and their countries. They promote international collaboration between their U.S. training site/sponsor and their country, both in scholarly persuits and by encouraging joint research. The role of the returning physician is significant and of great importance to the promotion of U.S. foreign policy. Activities which enhance the image of the U.S. and promote U.S. national interest should be supported by the Department of State.

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TESTIMONY OF

MIRIAM F. JACOBS

FOR THE

ACTION COMMITTEE FOR FOREIGN MEDICAL GRADUATES

BEFORE THE

COUNCIL ON GRADUATE MEDICAL EDUCATION

ON

NOVEMBER 19, 1987

TESTIMONY TO BE GIVEN BEFORE SUB-COMMITTEE

on

FOREIGN MEDICAL GRADUATES

by

MIRIAM JACOBS OF THE ACTION COMMITTEE

for

FOREIGN MEDICAL GRADUATES

I would like to thank the members of the Committee for allowing me the opportunity to present the views of the Action Committee for Foreign Medical Graduates for your consideration. We, as an organization, have been very active in bringing the legitimate concerns of foreign medical graduates in the United States to the attention of organized medicine and to local legislative leaders, and we appreciate the opportunity to do the same today. I am going to specifically address the draft conclusions/recommendations which are the subject of the Committee's deliberation. I will take these issues one at a time, but only discuss those points which we feel are of major concern to the foreign medical graduate community in the United States.

Regarding Issue 1, we feel, in agreement, with Conclusion 1.1. The exclusion of foreign medical graduates (FMG's) from residency training will have an adverse affect on current hospital services. We do not feel that alternative service providers will provide the same quality of service as foreign medical graduate residents in approved training programs.

Consequently, we do not agree on any federally mandated substitution or elimination of foreign medical graduate programs. In particular, we take issue with Recommendation 1.A.a. of the first draft. We feel that there is no reason for a mandated 90% residency level of LCME or AOA approved graduates in any qualified training programs. Training programs are approved by the residency review committees of the various specialty boards. These programs are under the direction of local program directors who evaluate applications and interview potential residents on a personal basis. To substitute a blanket percentage quota for the considered judgment of these experienced program directors is to institute a heavy-handed federal control where none is needed. The competition for residency positions is intense and foreign medical graduates are at a severe disadvantage. In accordance with Conclusion 3-2.4, we agree that the competition for available positions being very high, only the most highly qualified residents are selected "irrespective of citizenship or nationality". Consequently, we feel that market forces and private selection criteria are sufficient to provide quality residents in approved residency programs. Therefore, our recommendation is that a program approved by the Residency Review Committee of the specialty concerned should be funded regardless of the portion of American or foreign-trained physicians assuming residency positions therein. If the program does not attract sufficient American graduates, or the pass rates of the board examinations are too low, then, these issues are for the Residency Review Committee of the specialty to evaluate, and not for the federal government to use as an excuse for a back door attempt at regulation of foreign medical graduates. Therefore, we feel that there is no need for any percentage quota in evaluating a training program for funding. If the program is approved, then it should be funded. If the program is inadequate or substandard, then it should not be approved.

With regard to Issue 2, we are in agreement with Conclusion 2.1. We feel that graduates of foreign medical schools should not be distinguished by the fact of their medical school graduation for purposes of attaining graduate medical education from any other graduate of any other medical school, including the United States medical schools. The criteria for entry into graduate medical education training programs should be individual qualification, meeting appropriate examination standards and satisfying program directors of personal motivation, dedication and ability. The issue of medical school locations should only be one factor in this evaluation process. As I mentioned before, foreign medical graduates enter this competition at a distinct disadvantage. There has been a long-standing institutional prejudice in the United States against foreign medical graduates which has been supported by the United States Government. There is no compelling State interest for the continuation of this discrimination fostered by the U.S. Government policies when private, professional groups are capable of evaluating and managing this problem unaided. Evidence of the adverse impact on patient care because of inferior training or substandard performance of foreign medical graduates is lacking. As a matter of fact, studies of the incidences of medical malpractice claims show it to be to the contrary. The fact is that many specialties and program directors prejudge the quality of a program based upon the number of foreign medical graduates in the program. The directors of medical education are constantly reminded and called upon to account for the number of foreign medical graduates in their programs. They are told that their programs will be viewed in a better light if the number of FMG's are reduced. It seems to us self-evident that it is time to evaluate individual physicians on the basis of individual merit and not on the basis of the country of their education. Therefore, we are in agreement with Recommendation A.2.A. under Issue 2. In addition, we agree with Recommendation B.2.B. that United States citizens should receive preferential treatment with regard to access to graduate medical education than is given foreign nationals who intend to immigrate to the United States. This is not to say that foreign physicians who wish to avail themselves of the excellent training in the United States and who intend and agree to return to their home countries, should not be made exceptions to the rule. We do not feel that they should be included in any quota system of foreign medical graduates and in fact are opposed to the imposition of any quota system. However, in the alternative, if a quota system is imposed, we feel that alien physicians who are in the United States for training only, should not be part of the quota, but should be exceptions to the quota. Consequently, we are in general agreement with Issue 3 and its conclusions and recommendations.

With regard to Issue 4, we agree with Conclusion 4.1. We are on record for several years in support of the introduction of EQUALITY IN TESTING, as our position is that everyone seeking to practice medicine or apply for postgraduate medical education in the United States should be held to the same high standard. There should be one examination for everyone regardless of where the medical education was received. The implementation of this should not be held up until 1989 in this day and age of computerization, and especially when there are two existing examinations to choose from. We are in complete agreement with Recommendation 4.A, that the Federal Government should not attempt to add further requirements for FMG's for entry into graduate medical education programs as the private sector has moved responsibly into this area. While we do not agree with all of the actions taken by organized medicine, we feel that that is the proper forum for this debate and that is the correct arena for professional evaluation and review of medical training programs which are approved by appropriate professional review agencies. The authority to approve these programs for funding should be delegated by the agency to these review organizations in the private sector.

With regard to issue 5, we agree that this is a difficult and extremely complicated situation. It is probably impossible for the United States to provide recognition and accreditation for medical education outside of its jurisdiction. Nevertheless, it is probably an issue which should be left to the discretion of the States. If the States, who are basically responsible for regulating medical practice within their jurisdiction have determined that certain medical schools are worthy of approval for training programs or other operations within their jurisdiction, then the Federal Government should defer to the States' discretion in this area. This is supported not only by active precedent as the Federal Government has no licensing arrangement in any of the States, this being left solely to the discretion of the States. This is also supported by any rational interpretation of the 10th Ammendment to the United States Constitution.

I wish again to thank the Committee for allowing me the opportunity to present these views for your consideration. The bottom line consensus that I wish to leave you with is that the Action Committee for Foreign Medical Graduates feels that the imposition of federal control into graduate medical education is unwarranted, unwise and without a rational basis. These programs are now reviewed very strictly by the professional residency review committees and the Federal Government should continue its delegation to these organizations to review programs for approval. If programs so reviewed are approved, then they should be funded. Applicants for these programs should be selected by local program directors and no quota should be mandated by the Federal Government.

Thank you very much.

Signed:

Miriam F. Jacobs
for Action Committee on
Foreign Medical Graduates

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November 19, 1987

TESTIMONY OF KEVIN P. DONOVAN ON BEHALF OF THE NORTH AMERICAN STUDENTS' ASSOCIATION OF THE UNIVERSIDAD AUTONOMA DE GUADALAJARA BEFORE THE COUNCIL ON GRADUATE MEDICAL EDUCATION

Good afternoon Mr. Chairman and members of the Council, thank you for this opportunity to testify. I am Kevin Donovan, attorney for the North American Students' Association (NASA) of the Universidad Autonoma de Guadalajara (UAG). NASA's members are U.S. citizens studying at the medical school of the Universidad Autonoma de Guadalajara, in Guadalajara, Jalisco, Mexico.

NASA stands by the principle that each individual should be measured on the basis of merit. NASA, therefore, heartily supports the Council's Principles and the three Subcommittees' Conclusions and Recommendations adopted at the Council's meeting on October 6, 1987. These documents reflect a decision to focus on merit and public health and safety, rather than the false issues of oversupply and protection of physician incomes.

NASA praises the proposals of the Subcommittee on Foreign Medical Graduates which reflect concern with public health and fairness and the quality, not quantity, of physicians. The Subcommittee clearly states that there should be no discrimination against qualified applicants to Graduate Medical Education (GME) based on medical school attended, and that graduates of U.S. schools are not automatically guaranteed a GME position.

Some in U.S. medicine state that only graduates of U.S. medical schools should be permitted into GME because graduates of foreign medical schools do not have adequate medical knowledge. They base their argument on overall pass rates on questionable tests. These individuals and groups leave the realm of logic and reveal their true objectives, however, when they move to exclude not only graduates of suspect medical schools and those who cannot pass tests, but also graduates of established, legitimate medical schools, such as the UAG, that offer quality training, whose graduates have passed the tests and whose graduates have been licensed for decades by every medical board in the U.S. These individuals and groups ignore the published studies which show that foreign medical graduates and U.S. medical graduates provide equivalent health care. They also ignore the fact that 14% of faculty at U.S. medical schools are foreign medical graduates.

The Subcommittee notes that there have been questions raised about the equivalence of testing of U.S. and foreign graduates. There certainly are questions. NASA asserts that the two testing systems, one exclusively for graduates of U.S. and Canadian schools and the other for graduates of all other schools has only one purpose: discrimination. NASA has never heard any valid, scientific reason why the testing entity for medicine in the U.S., the NBME, refuses to permit graduates of foreign medical schools to take the same test of medical knowledge as do graduates of U.S. schools.

NASA understands that at this session there may be some announcement of the results of a study commissioned by the NBME or the ECFMG to determine the equivalence of the NBME and the FMGEMS. Since these organizations commissioned the study, NASA will be shocked beyond belief if the results say other than what the NBME and ECFMG have claimed all along, namely that the two tests are totally equivalent. If the testing goal of the NBME is, as it claims, to measure equivalence of medical knowledge of all applicants, it is a most unorthodox and unscientific method to produce two different examinations to measure comparability of skills. Every other profession fairly and correctly uses one test to measure competence. Assuming that the two tests are equivalent still begs the question: why are two different tests needed to test physicians who will be treating the same population?

NASA believes that any system that is truly dedicated to assuring equal quality of applicants will use one test. A dual testing system certainly gives the appearance of discrimination. NASA believes that the present testing system is discriminatory, and that the FMGEMS is a harder test than the NBME. I had a conversation with a physician member of a state licensing board who is a prominent faculty member at a major U.S. medical school. He has seen and administered the NBME and FMGEMS. He told me it is obvious that the two tests have two different purposes: the NBME is designed for people to pass, the FMGEMS is designed for people to fail. His comments make sense. When students at UAG could take NBME I for transfer purposes, their pass rates were approaching those of U.S. students. Now that UAG students are taking FMGEMS I, which is supposedly the equivalent of NBME I, their pass rate is far lower, yet the pass rates of U.S. students on NBME I have remained the same.

NASA challenges the NBME and the ECFMG to permit all applicants to take one test at the next sitting, either the NBME or the FMGEMS. NASA predicts that if the NBME is chosen, foreign student pass rates will rise; if FMGEMS is chosen, U.S. student pass rates will drop. NASA petitions this Council to recommend the fair way, the scientifically honest way, the non-discriminatory way, the way chosen by all other professions to measure comparability of knowledge: one test for all.

NASA supports the Council's Principle Number 1, which states that the primary concern of the Council must be assured access to quality health care, and that concerns for the well-being of the health professions must be secondary. NASA congratulates the Council on this clear assertion of dedication to public health.

COGME Principles number 2 and 8 also demonstrate the Council's dedication to health care concerns. Principle 2 addresses the need to assure physician coverage in rural and urban physician shortage areas. Principle 8 notes that health care needs will change based on demographics and disease patterns such as AIDS. Both of these principles are reflected in the recommendations of the Subcommittee on Physician Manpower, namely that no attempts should be made to limit numbers of physicians since there are currently many medically underserved areas in this country, and that the impact of AIDS and other as yet unknown diseases may turn any perceived short-term surplus of physicians into a critical shortage. Some in the medical community are calling for controls on numbers of physicians and on graduates of foreign medical schools; these persons and organizations either disregard the many federally-designated health care shortage areas, or they have concluded that sacrificing the health care of others is a fair trade-off in their quest to preserve their high incomes. NASA congratulates the Subcommittee and Council for ignoring these pressures to date and urges you to continue to resist the heavy lobbying pressure these groups will exert to protect their self-interests.

NASA supports the recommendation of the Subcommittee on Graduate Medical Education Programs and Financing which states that changes in GME financing should be undertaken in an evolutionary manner to avoid the adverse results that would result from sudden implementation. Areas that depend on GME medical services have evolved over time, and the relationships are too complex to be severed abruptly without causing serious adverse effects to the health care of those least able to afford the changes.

The Subcommitee did not make any recommendations on GME financing for foreign medical graduates because it had not yet received the report of the Subcommittee on Foreign Medical Graduates. NASA expects that any financing recommendations will logically follow the Foreign Medical Graduate Subcommittee's emphasis on merit selection rather than discrimination based on medical school attended.

I have given to staff a copy of my oral and written testimony to the Subcommittee on Foreign Medical Graduates on October 5, 1987, for its inclusion in the record; I will be pleased to supply it to individual members on request. Thank you for your attention. I will attempt to answer your questions.

NOVEMBER 19, 1987

TESTIMONY OF RICHARD RICHARDS
ON BEHALF OF THE UNIVERSIDAD AUTONOMA DE GUADALAJARA
BEFORE THE COUNCIL ON GRADUATE MEDICAL EDUCATION

I. INTRODUCTION

Good morning, Mr. Chairman and members of the committee. My name is Richard Richards. I am the Legislative Counsel for the Universidad Autonoma de Guadalajara. I would first like to thank you for the opportunity to testify before the full Council on Graduate Medical Education.

Before proceeding, I would like to express my appreciation to the Subcommittee on Foreign Medical Graduates for the professional manner in which the subcommittee conducted its hearings. I would further like to commend its Chairman, Dr. Whitcomb, for his leadership of the subcommittee and its members Drs. Mitchell, Peterson, Rodriguez and Mr. Groner and Ms. Apte for their diligence, demonstrated by their active participation. I was also impressed with the fairness of the subcommittee. Each of us had an opportunity to state our positions; the committee listened intently; good questions were asked; and I felt that all of the participants were treated fairly and given ample opportunity to present their case, for which the University is grateful.

In 1985 when the Congressional conferees on the Budget Reconciliation Act directed the creation of this Council, much trepidation spread throughout both the American and foreign medical education community. I must say, after reviewing the recommendations of the Subcommittee on Foreign Medical Graduates, that these fears have been laid to rest. We are pleased with the proposed COGME principles recommended by the Subcommittee, and look forward to a more in-depth discussion concerning some of said principles. We further pledge our active participation in the Council activities during its mandated tenure of existence.

The UAG supports the subcommittee resolution to issue #2, specifically that there should be no distinction between graduates of U.S. and foreign schools simply on the basis of the school attended. The standards to insure quality care in our communities must be placed on the qualifications of the individual. But these qualifications must be tested equally and uniformly. We further support the resolution to issue #3, specifically that any clinical test required for entrance to graduate medical education (GME) be applied to all applicants regardless of the geographical source of their education.

II. THE NATURE AND BACKGROUND OF THE UNIVERSIDAD AUTONOMA DE GUADALAJARA

First, I would like to briefly explain the Universidad Autonoma de Guadalajara (UAG), for it is truly unique amongst academic institutions. UAG is the oldest and largest private university in Mexico. Since its beginning, the institution has striven to overcome all obstacles to reach one goal, the successful operation of a co-educational, non-religious and non-profit university. At present, the University offers doctoral programs in several fields, and twelve masters degree programs. They train, among other professions, attorneys, engineers, architects, psychologists, educators, public administrators, linguists, and of course, physicians. The UAG is a major University. To that end the International Association of University Presidents recently elected UAG President Dr. Luis Garibay as their president, an exceptional honor to him and the University. The National Council of Science and Technology of Mexico has described the UAG as being "the most effective program with the finest teaching staff in the entire country."

To give you some idea of its size, UAG has a teaching staff of 1,500 faculty members, campuses of nearly 3,000 acres distributed over 16 sites, with a current enrollment of over 20,000 students.

UAG has graduated approximately 38,000 students from its inception, of which approximately 7,500 have been American citizens. The school was founded in 1935, making it now over 50 years old. It has a long and proud history.

Let me make it abundantly clear. The UAG is not an academic institution created by Americans for Americans outside the boundaries of the U.S. It was not created with the intention of usurping American medical educational institutions. Certainly, it is an alternative for U.S. students who do not, for various reasons, obtain admission to U.S. medical schools. To date UAG is approved in all states requiring preapproval inspections for the performance of clinical clerkships and is the only Foreign Medical School to be fully approved by the Education Department of the State of New York for clinical clerkships. This status is extremely difficult to obtain and maintain because of the high standards required by the state of New York.

UAG graduates are actively sought in many U.S. hospitals. In fact, last year over 80% of the applicants for resident matching received their notch. This statistic is commensurate with U.S. medical schools. This has been a brief overview of UAG, but graphic evidence attesting to the magnitude of the University and its programs.

III. THE UAG'S COMMITMENT TO ITS STUDENTS

UAG is proud of its institution, its students and its faculty. Its primary commitment to its students is to provide a good medical education, and secondly, to do all within its power to insure its students, once they have graduated, that there will be an opportunity to practice medicine throughout the world, including the United States, and to assist the students in combating discriminatory practices of whatever nature and wherever they may be found.

We on behalf of UAG have worked with Congress to initiate and enact laws that preclude such discrimination. It was UAG who joined the medical care community when the proposal was made in Congress to deny Medicare reimbursement to teaching hospitals for FMG residencies.

Our efforts further extended to the proposal for elimination of Guaranteed Student Loans to U.S. FMG's attending foreign medical schools. Through the efforts of UAG, the law now only precludes loans to students who attend schools which do not have a student population of at least 60% country nationals or a 50% pass rate on FMGEMS, thus protecting legitimate medical schools, but denying protection to so-called "diploma mills."

These efforts have not been limited to the Congress. UAG maintains an active presence in many state legislatures, including New York, New Jersey, California and Pennsylvania. At present New York's legislature is debating the issue of utilizing one single testing for licensure in New York State. Last year during its annual meeting the CME of the AMA directed the EFMG and the NBME to examine the possibility of utilizing one exam. We wholeheartedly support uniform testing and urge your committee to embrace this concept and include it in your recommendations. To do so would be a major step forward to insure uniform high quality of the physicians in our hospitals.

In closing, I would again like to thank the Chairman, the Council and particularly the Subcommittee on Foreign Medical Graduates for their work and would like to reiterate our pledge to work with you now and in the future to insure the best possible medical care for the people of our nation. Thank you.

Presentation

To

The Council on Graduate Medical Education

By

James E. Cassidy, B.A., D.M.D., M.P.H., Dr. P.H.

President, Ross University

My name is James Cassidy. I am president of Ross University which numbers among its educational institutions, a School of Veterinary Medicine, an Information Systems Institute, and a School of Medicine.

I am here today, of course, to discuss matters that may impact on our School of Medicine, its students, and its graduates.

As I am sure all persons attending this hearing have done, I read with great interest the Council's Recommended COGME Principles, and the Preliminary Recommendations and Conclusions of the Council's three subcommittees.

Speaking on behalf of the hundreds of men and women, many of them American citizens, who matriculate at our School of Medicine, much of what has come out of the diliberations of the Council and its subcommittees, we find, with the exception of several issues I will raise, that the recommendations and conclusions made so far are valid and equitable.

Through the reading of the notice for this hearing, published in the Federal Register, I learned that "Issues Relating to Foreign Medical graduates" is one of the matters the Council was directed to consider. I have no knowledge, however, of why the subcommittee on FMG's chose to interpret that directive as requiring that its first order of business be to consider what the effect on the availability of hospital based services would be if FMG's were to be removed from hospital training.

The Subcommittee did identify a number of seriously negative effects such action would have, especially if it were enacted abruptly. However, the Subcommittee has not as yet, at least, recommended or concluded that such an action should not be taken.

In consideration of several related matters, it follows logically that a recommendation that FMG's *not* be removed from hospital training should be made by the Council. The Council has stated that, "the primary concern of the Council must be the health of the American people".

Although there is an additional major reason that I will mention for not removing FMG's from hospital training, I see no way, in a time when the Federal and State governments are in difficult financial straits, to find funding for replacement of FMG residents. The cost would be prohibitive, which leads therefore to the conclusion that to provide health care for large segments of the American people, continuing the appointment of FMG's to residency training is the only feasible course of action - at least for the foreseeable future.

Related to this matter is the report given to the Council at its third meeting by Dr. Vaneslow. In his report on visits he and Mr. Schwab made to various federal officials, Dr. Vaneslow stated that in his view, "Congress was willing to consider proposals to restrict FMG's, but was deeply worried about access of the poor to health care, whether FMG's should be excluded from serice positions, and equitable treatment of American citizens, wherever they had received their medical education".

In consideration of the current acute need for fiscal restraint, Congress' concern about access of the poor to health care substantively reenforces the rationale for recommending that FMG's not be removed from hospital training. Such a recommendation would support principle number 6 of the Council, concerned as it is with effects on total health care costs.

Further, the concern for equitale treatment of all American citizens, wherever they had received their medical education must be noted. If there is a legal or rational basis for considering where an American citizen took his or her medical education as being more important than his or her right as a citizen to equitable treatment, I do not know what it is.

The one distinction that comes to mind that members of the Council might make would refer to the Council's principle number 9, having to do with the quality of medical care and appropriately educated physicians.

I am concerned about what seems to be the belief among many American health professionals and public officials that ipso facto any graduate of an LCME accredited medical school is better qualified than every graduate of any foreign medical school.

Underlying that belief seems to be a conviction that the process of education in LCME accredited schools ensures the quality of products of those schools. Yet, even a cursory examination of the curricula of LCME schools raises a number of questions about the validity of that conviction.

The first question that comes to mind is which process of education in which school?

This question devolves from the fact that there exist wide variations in what is taught in LCME schools. Examples*

Basic Medical Sciences

Range of Total Hours Taught:		1028 - 2430	
Range of Hours in Disciplines:		135 - 612	
	Anatomy	145 - 341-	Pathology
	Physiology	90 - 340	
	Microbiology	66 - 291	
	Biochemistry	55 - 272	
Range of Weeks of Clerkships:			
	Total -	70 - 110	
	Medicine	4 - 24	
	Surgery	4 - 22	
	Pediatrics	4 - 13	
	Ob/Gyn	4 - 12	
	Psychiatry	2 - 10	

Further questions are raised about the process of education in American medical schools by the prestigious Panel that prepared the report Physicians for the Twenty-First Century; particularly in the reports of the working groups.

*Swanson, "Medical Education in the United States and Canada, Journal of Medical Education, Nov, 1984

Questions raised had to do with matters such as overloading of subject matter by highly specialized basic science faculty members, fragmentation of subject matter as presented by a multitude of highly specialized faculty members, failure to integrate basic and clinical science studies, failure of medical schools to reward undergraduate teaching, and the suitability of tertiary care hospitals as educational sites for medical students.

My point in raising these questions is to support my contention that there exists no such thing as a process of medical education in LCME schools. There are as many processes as there are schools. Therefore, it is not the process of education that should be looked at, but rather the product.

With this in mind I strongly support the recommendation of the Subcommittee on FMG's that one examination be used for all applicants for entrance into graduate medical education.

Finally, I fully support the recommendation of the Subcommittee on Physician Manpower that at present the Federal Government need not attempt to influence physician manpower supply in the aggregate.

On the one hand, the Subcommittee, which predicts a developing oversupply of physicians, recognizes the potential for a number of social benefits deriving therefrom. On the other hand as recognized inherently in the Subcommittee's list of supply and demand variables, the future is difficult to predict.

In New York City, for example, a city in which a few years ago discussion was underway about the reduction of total bed capacity by 20 percent, discussions now center around how many additional beds are needed and how quickly they can be made available.

In summary, I congratulate members of the Council on progress they have made thus far and ask that when meeting in plenary session they seriously consider the points I have made about access to hospital training for FMG's, and particularly for USFMG's.

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TESTIMONY OF

CHARLES R. MODICA, J.D.
CHANCELLOR
ST.GEORGE'S UNIVERSITY
SCHOOL OF MEDICINE
GRENADA, WEST INDIES

BEFORE THE

COUNCIL ON GRADUATE MEDICAL EDUCATION

CONCERNING

GRADUATE MEDICAL EDUCATION,
FOREIGN MEDICAL GRADUATES
AND
ST. GEORGE'S UNIVERSITY SCHOOL OF MEDICINE

ON

NOVEMBER 19, 1987

Members of the Council on Graduate Medical Education, I am very pleased to appear before you to discuss issues related to Foreign Medical Graduates and St. George's University School of Medicine.

First, please allow me to commend the Council for the action you have taken over the past year to partake a thorough review of the issues related to Graduate Medical Education financing, and for the comprehensive approach you are taking to recommend improvements.

Since St. George's was founded in August of 1976, nearly 800 students have graduated with degrees in medicine, many of whom return to the United States to practice in underserved areas. Often in inner-city area teaching hospitals that treat great numbers of low-income and indigent patient populations, 80-90% of residency positions are filled by graduates of foreign medical schools. There would be a significant problem in handling the patient load in many of these hospitals if not for residency slots being filled by eager graduates from non-U.S. schools such as St. George's. The Journal of the American Medical Association, in its January 18, 1985 issue, reported that St. George's University School of Medicine had the highest initial pass rate of all the leading foreign medical schools in the world on the U.S. Qualifying Examination (the ECFMG). As each class at St. George's finishes its second year of medical education, approximately one-third of that class transfers to U.S. medical schools to complete their education.

I would like to advise you of two significant developments that are central to the continued progress of our school as a recognized producer of quality medical graduates.

First, the New York State Department of Education has reached a decision that approves the placement of third and fourth year students from St. George's to begin clinical clerkships at several of New York's teaching hospitals. About 60 of our third and fourth year medical students are engaged in two-year clerkships at Brooklyn Hospital, Methodist Hospital, and Coney Island Hospital, in Brooklyn.

The approval by New York , along with a similar 1985 decision by New Jersey, clearly demonstrates the confidence placed in St. George's by independent State Education Departments after on-sight reviews of our campuses. The approval by New York makes St. George's the only foreign school offering medical education in English that has an approved campus in New York State.

Second is, that during last year's rewrite of the Higher Education Act Authorization, Congress recognized the significant contribution that St. George's University School of Medicine makes in the education of a significant number of U.S. citizens who return to the United States after their medical education to become outstanding practicioners of medicine. The Higher Education Act now contains specific criteria that would eliminate most Guaranteed Student Loan opportunities for U.S. students attending foreign schools. But, during consideration, Congress included provisions continuing GSL eligibility for U.S. students who attend schools that have a pass rate of 45% or better on the examination administered by the Educational Commission for Foreign Medical Graduates (ECFMG). Under this criteria, St. George's is the only Carribean institution that qualifies, because of its comparatively high pass rate.

I mention these two developments for several reasons, but primarily to demonstrate that St. George's is being recognized and singled out as an institution that provides a level of quality education that is not found at many other foreign medical schools. And, that the approval of the states of New Jersey and New York to utilize and train graduates of St. George's suggest they are filling a manpower need not currently being filled by available domestically trained medical graduates.

We have reviewed the draft conclusions and recommendations of the COGME Subcommittee on Foreign Medical Graduates. Based on this information we can conclude that the Subcommittee has conducted an extensive review of many of the pertainent issues surrounding Foreign Medical Graduates, and can only recommend that the Council seriously consider, and recommend in its report that these conclusions be drawn upon by decision makers in Congress, federal agencies, and organized medicine.

The extensive review conducted by the FMG Subcommittee points out several items that I wish to reiterate:

ISSUE 1)

Conclusion 1.1 states that the exclusion, abrupt or phased, of FMG's from residency training will impact current hospital based services. Conclusion 1.4 describes the extensive disruptions in service in 84 large public and non-profit teaching hospitals in several states, and further points out that these hospitals have between 25% and 100% FMG dependency and have very high indigent care service population. Recommendation 1.A. cautions against reducing GME financial support for FMG's until adequate health care delivery alternatives are available.

ISSUE 2)

Conclusion 2.1 states that no person, including a graduate of a U.S. Medical School, has an absolute right or entitlement to a graduate medical education position. Conclusion 2.2 says that if the Government has no factual basis forcategorically denying public funds for graduates of Foreign Medical Schools it could be considered constitutionally discriminatory. Recommendation 2.A. states that the Federal Government should not differentiate among graduates from Foreign Medical Schools based on citizenship or immigration status in actions which may affect access to GME.

ISSUE 3)

Conclusion 3.1 states that there is a strong possibility that US relations with foreign countries will be harmed if educational opportunities for international exchange visitors are reduced as a by product of general reductions in Graduate Medical Education opportunities. Recommendation 3.A. states that exchange visitors in traditional GME should continue to be supported like all other participants in GME.

ISSUE 4)

Recommendation 4.A. says the Federal Government should not attempt to add further evaluative requirements for FMG's for entry into Graduate Medical Education programs. It is further recommended that, for credibility purposes, assurances of the comparability of current screening examinations be implemented. The provision of one examination for all entrants into GME is recommended if it is the only means to achieve this.

ISSUE 5)

Conclusion 5.1 states that it would be presumptuous and unwise for the United States to attempt to provide recognition or accreditation for medical education outside its domain. Recommendation 5.A. says that the Federal Government should not enter into the establishment of a system for recognition or accreditation of Foreign Medical Schools.

The conclusions and recommendations of your group, carefully studied and thought out througout the last year speak for themselves. Clearly this comprehensive review of the issues related to Foreign Medical Graduates has confirmed the critical need to continue Graduate Medical Education support for graduates of foreign medical schools. Now is the time for Congress, the Federal Government, and organized U.S. medicine to recognize the contribution that Foreign Medical Graduates make to the health care of millions of Americans, and the important role they play in todays delivery system.

Thank you for the opportunity to present our views and, again, thank you for the comprehensive approach you have taken to review this important issue.

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HEALTH MANPOWER COMMITTEE
November 16, 1987

I. COGME

a) 14 societies have submitted their Physician Supply Matrices in a form suitable for submission to COGME.

II.

1) We support COGME in general principles concerning the health of American people

2) We again want to bring to your attention the eight principles adopted by CMSS concerning the financing of Graduate Medical Education

Financing of Graduate Medical Education - Eight Principles

1. Federal funds should continue to support GME in the United States
2. Other patient care funds should continue to support GME in the United States
3. Federal funds should support graduates of LCME-approved medical schools only
4. Federal funds should support resident in ACGME-approved programs only
5. Funding should provide support to allow every graduate of an LCME-approved school to obtain necessary GME
6. Separate funding should support the GME of alien foreign medical graduates who will return to their native country to practice
7. Studies to determine physician specialty and geographic manpower needs should be encouraged and supported
8. Numbers of residency positions, by specialty and by location, should be based on the adequacy of patients, teachers and facilities, as monitored by ACGME

3) We recognize that COGME is chartered for 10 years, but we are concerned that its budget and staff is limited. Your activity must be scholarly. You can be a leader, an advocate to protect the scholarly nature of GME, a protector of it from political decisions that might result in major damage to the quality education our physicians currently receive.

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4) We recognize that the length and content of residencies for individual specialties do vary according to the discipline. Through the years these requirements through the years have been set by scholars heavily involved in and concerned with the appropriate education of our future practitioners. Arbitrary decisions could be made in the development of a cost-saving reimbursement policy that would result in reduced support for GME and grossly interfere with the quality of GME teaching and research.
(Indirect costs.)

5) FMG - CMSS recognizes our obligation to alien graduates of foreign medical schools who would benefit from training here and return to their native land. CMSS supports the development of IMSP (International Medical Scholars Program) and lauds COGME for its supportive stance.

6) CMSS supports your efforts to increase opportunities for minorities in the health care field.

7) COGME has taken the position that in the aggregate there is and will be an excess of physicians. With this we agree. The definition of surplus or shortage is difficult. The positive or negative effects on the health care of our citizens is unknown. The definition of a surplus or shortage must include the possibility of the development of new technology, new modalities of treatment and the appearance of new diseases such as AIDS.

III. Either on their own and/or at the suggestion of CMSS, many of our societies have developed resident tracking programs -- one of them reported the other day -- highlights of the ACS report are as follows.

Update -- Tracking of Surgical Residents
-- ACS. Glen Misek

a) 1983-84 - peak of surgical residents - 14,888; decline over next 3 years

1986-87 -- that is expected to continue -- 14,428 - 3.1%

20% below that predicted by GMENAC

b) FMG residents -- all surgery decreased by 48.6%
Since 1982-83 - 2110 -- 1048 down each year, mostly male

c) Females increase 1100 to 1300

d) US males up 703 or 6.3%

e) Cohort of surgical residents 1982-83 PGY-1

82-83 - 3057
83-84 - 2065
84-85 - 1240
85-86 - 1022
86-87 - 1036

Will lose over next 2 years approximately 350 to Plastic and Reconstructive, Colon and Rectal and Vascular Surgery Residents in General Surgery approximately 625.

The ability to track residents throughout their GME and on into practice is essential to your efforts. Otherwise what appears to be in the pipeline may certainly not be so.

I want to thank you for the opportunity to appear before you on behalf of CMSS and particularly its Manpower Committee. CMSS stands ready to be of assistance to you in your efforts.

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TESTIMONY OF THE

AMERICAN ACADEMY OF FAMILY PHYSICIANS

BEFORE THE

COUNCIL ON GRADUATE MEDICAL EDUCATION

Presented by

George A. Dean, M.D.
Member, Board of Directors

November 20, 1987

I am George Dean, M.D., a member of the Board of Directors of the American Academy of Family Physicians. I also serve as chairman of the Commission on Education and as a clinical associate professor at Wayne State University. On behalf of our more than 60,000 members, I am pleased to have the opportunity to appear before the Council today to share the views of the Academy on the important issues surrounding graduate medical education. We hope that this information will assist the Council in the preparation of its first report to Congress, due in July 1988.

The federal government has a responsibility for helping ensure access to quality health care by the American people. Integral to the assurance of access is a supply of physicians appropriate to meet the demand for care. Because of this relationship, the Academy believes that the federal government does have an appropriate and crucial role in supporting graduate medical education through both the Medicare program and targeted Public Health Service grant programs.

The Council has stated in its principles #2 and #8 that it should consider the diverse needs of various geographic areas and segments of the population as well as changing patterns of health care delivery in developing its recommendations. We agree wholeheartedly with these principles and believe that the specialty of family practice is helping to meet the needs of diverse populations for health care. We would like to share with you information about the specialty of family practice--where our members locate, how they practice, and for whom they care.

Family practice is the premier primary care specialty in the United States, providing comprehensive, continuing care to all members of the family. Family physicians provide ambulatory-based, cost-effective, preventive-oriented care to a broad population of this country. According to 1985 data from the National Ambulatory Medical Care Survey, 30.5 percent of visits to office-based physicians in the U.S. were to family physicians (Attachment A).

LOCATION OF FAMILY PHYSICIANS

Family physicians are continuing to locate in shortage and rural areas in notably larger proportions than other medical specialties, thus helping to address the national problem of geographic maldistribution. Data from the 1986 survey of family practice residency graduates indicates that 90 percent enter active family practice and over 47 percent locate their practices in rural and suburban communities of less than 25,000 (Attachment B). Because of their multidisciplinary training, family physicians are able to care for 85 percent of the problems that present in their offices and are particularly adaptable to the diverse needs presented in the various geographic areas.

FAMILY PRACTICE AND GERIATRICS

Geriatric health care is an important part of the family physician's training and practice. Care provided by family physicians is aimed at keeping the elderly person active, mobile and self-sufficient. According to 1985 data from the National Ambulatory Medical Care survey, visits to family physicians represented 29.1 percent of the visits to all physicians by the nation's 26.6 million residents age 65 and over (Attachment C).

In response to the changing demographics of the population, and in recognition of the specialized body of knowledge and approach to patient care of the elderly, the American Board of Family Practice and the American Board of Internal Medicine have collaborated to develop an examination in geriatric medicine. Those passing the examination will be awarded a certificate of added qualifications in geriatrics. It is important to note that eligibility to take this examination is contingent on current board certification in family practice or internal medicine. The certificate does not convey subspecialty status, nor does it create a new specialty of geriatrics. The ABFP recognizes that geriatrics is one important part of the practice of family practice and, because of that requires that the candidate for added qualifications always be currently certified and recertified in family practice. Geriatrics is an integral part of family practice residency training and an integral part of family practice.

In its principle #8, this Council has noted that it must take into account changes in demographics in formulating its recommendations. One of the changes highlighted is the aging population. The Academy would emphasize to the Council that, as described above, family physicians are presently providing their aging patients with quality health care. We therefore believe that the need for additional family physicians to care for the elderly should be considered by the Council in developing its conclusions and recommendations regarding physician supply requirements to care for the aging population.

DEMAND FOR FAMILY PHYSICIANS

The demand for family physicians is significant and increasing. With the tremendous expansion of the managed care industry and increased emphasis on cost-effectiveness, family practice residency-trained graduates are at a premium, sought after to manage those systems. Communities, particularly in rural areas, continue to seek family physicians to meet their comprehensive health care needs. Trends in Medicare call for alternatives to costly inpatient care and emphasize the type of less expensive ambulatory-based care provided by family physicians.

Medicaid and Family Practice:

A significant portion of office based physician services received by Medicaid recipients is provided by family physicians. According to HCFA data in FY85 there were 21,800,000 Medicaid recipients. Since Medicaid recipients cover all age groups (though perhaps greater numbers of women and children) and the program varies greatly from state to state, it is not possible to determine the exact percentage of Medicaid recipients treated by any specialty. However, extrapolating from the 1985 NAMCS, one could assume that, since visits to family physicians represent 30.5 percent of all visits to all office based physicians as compared with 11.6 percent to internists, 11.4 percent to pediatricians and 8.9 percent to obstetricians/gynecologists, a comparable differential could be used for percentages of Medicaid patient visits.

Pediatrics and Family Practice:

Data indicate that family physicians care for a significant percentage of the pediatric age population. In 1985, 51,905,000 U.S. residents were under 15 years of age, representing 22.6 percent of the total resident population.[1] The NAMCS that same year reported that 18.7 percent (118,769,000 visits) of total visits to office-based physicians were visits by patients under 15 years of age. Visits by patients under 15 to family physicians totaled 29,659,000, which represents 25 percent of the visits by patients under 15 years (Attachment C). Though pediatric care may be given to some patients 15 and older and a portion is given in other than the ambulatory setting, when assessing the delivery of primary care, it is realistic to state that 20 to 25 percent of pediatric care is provided by family physicians.

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[1] Current population Reports, Population Estimates and Projections. Series P-25, No. 985:20-21.

Because of the breadth of services provided to all age groups by family physicians, the need for family physicians in rural and underserved areas, and the demand for family physicians in prepaid medical care delivery systems, the Academy believes that the supply of family physicians must be increased.

SUPPLY OF FAMILY PHYSICIANS

Concurrent with the increased demand for family physicians is a supply unable to keep pace. With more than one-third of family physicians/general practitioners age 55 and older, attrition from practice for this age group is expected to be high. The number of family practice residency programs, which experienced tremendous growth from the inception of the specialty in 1969 until 1982, has now leveled off at approximately 382 programs with 2456 first year residents.

The growth of family practice residency programs began to level off in 1983, paralleling the leveling off of federal support of family practice training programs.

The total number of residents in family practice residency programs in July 1986 was 7446, a slight drop from the 1985 high (Attachment D). Minority residents represented 11.6 percent of this 1986 population and female residents represent 27.7 percent (Attachments E and F). As a percentage of the total resident population in 1985, family practice represented 9.8 percent, and the combined primary care specialties of family practice, pediatrics and general internal medicine represented only 30.5 percent of total residency positions.[2] [3]

As a new specialty with a unique training model family practice has been faced with difficult financial constraints. Over two thirds of residency programs are located in community hospitals affiliated with universities, rather than located in traditional tertiary medical centers. The AAFP is making a significant effort to increase family practice residency affiliation with community health centers, migrant health centers and free clinics. Due to the emphasis on ambulatory, preventive care, reimbursement from Medicare and other third party payors is significantly less than for inpatient, procedurally oriented services. The federal support provided to graduate medical education through the Medicare program, although less for family practice than for other training programs, remains an important source of financial viability. Targeted federal support through the Public Health Service grants continues to be extremely important to both residency programs and departments of family medicine within medical schools.

The family practice residency program consists of three years of specialty training that includes the disciplines of internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry, problems of aging and community medicine. As noted above, the majority of program are located in community hospitals affiliated with universities, rather than located in traditional tertiary medical centers. One-half of the program are in hospitals that have only a single residency training program. Various studies of these programs indicate a cost distribution of about one third resident salaries/fringe benefits, one-third faculty and administrative costs, and one-third overhead costs of the family practice center.

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[2] Medical Education in the U.S. 1985-1986. JAMA 1987;256(12):1588.

[3] Kallenberg G, Riegelman R, Hockey L. Waiting for the Doctor Glut, or is the Calvary Really Coming. Journal of General Internal Medicine. 1987;2:252.

Revenue sources are largely comprised of government support, practice revenues and hospital support. Over two-thirds of family practice programs have direct state support, and one-half of the programs have had federal training grant support.

Patient care revenues have been unable to support the training programs and it appears unlikely they ever will be able to do so under the current reimbursement structure. Experience indicates that revenues from patient care have been able to fund only one-third of the cost of family practice residency training. Typically, Medicare reimbursement for ambulatory-based, preventive-oriented services is significantly less than for procedurally-oriented inpatient services. This also tends to be the case for other third party payors. As a result, family practice training with its ambulatory emphasis, is unable to become "self-sufficient" from patient care revenues under the present Medicare reimbursement scheme.

According to the report "Impact of Federal Support on Family Practice Residency Training," prepared for the Department of Health and Human Services, federal funding has been positively associated with the formation and stability of family practice residency programs.[4] For example, from 1979 to 1984, unfunded programs expired 3.7 times more often than funded programs. In recent years the role of federal funding has shifted from new program growth to program support and maintenance; this has been coincidental with the leveling off of federal support. The report further notes that the absence of federal funding may have disproportionately severe consequences for smaller and community based family practice residency programs.

The Academy encourages COGME to study the financial disincentives to ambulatory based residency training and to develop recommendations to Congress which would shift Medicare incentives in the direction of primary care training. In the budget reconciliation legislation now being considered in Congress, both the House and Senate packages include provisions which would increase Medicare reimbursement for primary care services at a higher rate than for other physician services. We believe that this is an important step toward the long term reform of the Medicare program, which ultimately may have positive implications for family practice training.

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[4] Kelly N, Franklin S, Hubbard S, Huse D. Impact of Federal Support on Family Practice Residency Training. Report prepared for the Department of Health and Human Services, 1986;6.

In view of the above, we are concerned that the preliminary recommendations of the Manpower Subcommittee under "specialty supply" do not call for a federal role. The Academy encourages the Council to recognize the significant role that federal funds have played in the initial development, growth and maintenance of family practice programs and to consider recommending an increase in the targeted federal support to family practice training programs.

CONCLUSION

In summary, the American Academy of Family Physicians believes that the goal of assuring access to quality health care by the American people as emphasized in the Council's first principle can be met only if the supply of physicians is appropriate to meet the demand for services. Given the current demand for the services of family physicians, the supply is inadequate and will remain so without deliberate efforts to train more family physicians. We encourage the Council on Graduate Medical Education to take into account the continuing federal responsibility for helping to address access to care through sound health manpower policies and to develop recommendations which reflect this commitment.

II-B-1 NUMBER AND PERCENT DISTRIBUTION OF OFFICE VISITS BY PHYSICIAN SPECIALTY, TYPE OF PRACTICE, AND PROFESSIONAL IDENTITY: UNITED STATES, 1985

Physician Specialty, Type of Practice and Professional Identity	Number of Visits in Thousands	Percent Distribution
TOTAL Visits	636,386	100.0
Family Practice	193,995	30.5
Internal Medicine	73,727	11.6
Pediatrics	72,693	11.4
Obstetrics and Gynecology	56,642	8.9
Ophthalmology	40,062	6.3
Orthopedic Surgery	31,482	4.9
General Surgery	29,858	4.7
Dermatology	24,124	3.8
Psychiatry	17,989	2.8
Otorhinolaryngology	16,097	2.5
Urological Surgery	11,699	1.8
Cardiovascular Disease	10,617	1.7
Neurology	4,992	0.8
All Other Specialties	52,408	8.2
Type of Practice		
Solo	323,653	50.9
Partnership	113,317	17.8
Other[1]	199,416	31.3
Professional Identity		
Doctor of Medicine	600,514	94.4
Doctor of Osteopathy	35,872	5.6

[1] Includes group practice and other.

Source: *U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, 1985 Summary: National Ambulatory Medical Care Survey, January 23, 1987, Number 128, p. 3.*

ATTACHMENT B

REPORT ON SURVEY OF 1986 GRADUATING FAMILY PRACTICE RESIDENTS

The total number of graduates surveyed was 2,306. Of this number, 1,868 (81%) responded. Of these respondees, 1,861 indicated the type of practice arrangement and 1,595 specified the size of the community in which they plan to serve. A summary of the results as of July 1986 follows.

The data from 1977, 1978 and 1979 has been reanalyzed to conform with the 1980-1986 statistics. Caution must be exercised in comparing data previous to 1977 because of changes made to data analysis. However, the revised 1977-1979 data may be directly compared with the 1980-1986 data with confidence.

Practice Arrangements of 1986 Graduating Residents

Type of Practice Arrangements	*Number of Reporting Grads*	*Percentage of Total Reporting Grads*
Family Practice Group	457	24.6%
Multi-Specialty Group	202	10.0%
Two-Person Family Practice Group (Partnership)	277	14.9%
Solo	191	10.3%
Practice (arrangement not specified)	78	4.2%
Military	139	7.5%
Teaching	37	2.0%
USPHS	185	9.9%
Emergency Room	82	4.4%
Hospital Staff	25	1.3%
Research	8	.4%
Administrative	0	.0%
Further Training	32	1.7%
Fellowship	53	2.8%
None of the Above	95	5.1%
	1,861	100.0%

Distribution of 1986 Graduating Residents by Community Size

Character and Population of Community	*Number of Reporting Grads*	*Percentage of Reporting Grads*	*Cumulative Percentage of Total Reporting Grads*
Rural area or town (less than 2,500) not within 25 miles of large city	153	9.6%	9.6%
Rural area or town (less than 2,500) within 25 miles of large city	65	4.0%	13.6%
Small town (2,500-25,000) not within 25 miles of large city	321	20.1%	33.7%
Small town (2,500-25,000) within 25 miles of large city	218	13.7%	47.4%
Small city (25,000-1000,000)	264	16.6%	64.0%
Suburb of small metropolitan area	63	3.9%	67.9%
Small metropolitan area (100,000-500,000)	170	10.7%	78.6%
Suburb of large metropolitan area	183	11.5%	90.1%
Large metropolitan area (500,000 or more)	119	7.5%	97.6%
Inner city/low income area (500,000 or more)	39	2.4%	100.0%
	1,595	100.0%	

II-B-2 NUMBER AND PERCENT DISTRIBUTION OF OFFICE VISITS BY SEX AND AGE OF PATIENT AND BY FAMILY PHYSICIANS AND OTHER PHYSICIANS: UNITED STATES, 1985

Sex and Age of Patient	All Physicians		Family Practice Physicians		Other Physicians[1]	
	Number of Visits in Thousands	Percent Distribution	Number of Visits in Thousands	Percent Distribution	Number of Visits in Thousands	Percent Distribution
TOTAL	636,386	100.0	193,995	100.0	442,391	100.0
Female						
TOTAL Female	387,481	60.9	117,685	60.7	269,795	61.0
Under 15 years	58,175	9.1	14,699	7.6	43,475	9.8
15-24 years	48,883	7.7	16,679	8.6	32,204	7.3
25-44 years	118,557	18.6	35,797	18.5	82,760	18.7
45-64 years	82,331	12.9	26,915	13.9	55,416	12.5
65 years and over	79,535	12.5	23,595	12.2	55,940	12.6
Male						
TOTAL Male	248,906	39.1	76,310	39.3	172,593	39.0
Under 15 years	60,594	9.5	14,360	7.7	45,633	10.3
15-24 years	25,081	3.9	9,672	5.0	15,408	3.5
25-44 years	57,167	9.0	20,251	10.4	36,917	8.3
45-64 years	55,060	8.7	17,081	8.8	37,978	8.6
65 years and over	51,004	8.0	14,346	7.4	36,657	8.3

[1] Excludes physicians in anesthesiology, pathology or radiology.

Source: *U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, National Ambulatory Medical Care Survey, unpublished data.*

ATTACHMENT C

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ATTACHMENT D

I-B-1 FAMILY PRACTICE RESIDENCY GRADUATES BY YEAR OF COMPLETION, JULY 1987

Year of Completion	Number	Cumulative Total
TOTAL	21.864	
1970	35	35
1971	43	78
1972	108	186
1973	181	367
1974	340	707
1975	594	1,301
1976	856	2,157
1977	1,137	3,294
1978	1,486	4,780
1979	1,741	6,521
1980	1,865	8,386
1981	2,058	10,444
1982	2,159	12,603
1983	2,178	14,781
1984	2,262	17,043
1985	2,424	19,467
1986	2,359	21,826
Unknown	38	21,864

Source: *American Academy of Family Physicians.*

ATTACHMENT E

V-A-1 NUMBER OF RESIDENTS IN FAMILY PRACTICE RESIDENCY PROGRAMS[1] BY MINORITY STATUS[2], JULY 1986

Program Year/Minority	Number	Percent
TOTAL	7,446	100.0
Non-Minority	6,580	88.4
Minority	866	11.6
PGY-1	2,473	100.0
Non-Minority	2,170	87.7
Minority	303	12.3
PGY-2	2,510	100.0
Non-Minority	2,216	88.3
Minority	294	11.7
PGY-3	2,463	100.0
Non-Minority	2,194	89.1
Minority	269	10.9

[1] 381 approved programs.

[2] Black, Mexican-American, American Indian, and others.

Source: *American Academy of Family Physicians, Residency Census Survey, 1986.*

ATTACHMENT F

V-A-2 NUMBER OF RESIDENTS IN FAMILY PRACTICE RESIDENCY PROGRAMS[1] BY SEX, JULY 1986

Program Year Sex	Number	Percent
TOTAL	7.446	100.0
Male	5.384	72.3
Female	2.062	27.7
PGY-1	2.473	100.0
Male	1.780	72.0
Female	693	28.0
PGY-2	2.510	100.0
Male	1.799	71.7
Female	711	28.3
PGY-3	2.463	100.0
Male	1.805	73.3
Female	658	26.7

[1] 381 approved programs

Source: *American Academy of Family Physicians. Residency Census Survey. 1986*

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American Academy of Pediatrics

TESTIMONY

BEFORE THE

COUNCIL ON GRADUATE MEDICAL EDUCATION

ON

PEDIATRIC MANPOWER AND TRAINING

PRESENTED BY

ROBERT JOHNSON, M.D., F.A.A.P.

on behalf of

Ambulatory Pediatric Association
American Academy of Pediatrics
Association of Medical School Pediatric Department
Chairmen

November 20, 1987

Mr. Chairman and members of the Council on Graduate Medical Education (COGME), I am Dr. Robert Johnson, Director, Adolescent Medicine and Associate Professor of Clinical Pediatrics, New Jersey Medical School. I am here on behalf of the American Academy of Pediatrics (AAP), the Ambulatory Pediatric Association (APA), and the Association of Medical School Pediatric Department Chairmen, organizations dedicated to the health, safety and well-being of infants, children, adolescents and young adults. Our organizations are committed to ensuring that future generations of children and adolescents receive quality health care.

Our purpose in testifying before you today is to assist the Council in its efforts to make responsible graduate medical education and physician manpower recommendations to the Congress. While we recognize the high degree of uncertainty inherent in estimating the optimal match between future children's health needs and manpower requirements, to err in this endeavor places the health of the country at risk.

I would first like to respond to the COGME's preliminary conclusions regarding the overall supply of pediatricians. Second, I will discuss two major problems which we believe frustrate and impede efforts to predict future requirements for pediatricians -- the unmet needs of children's health care and the maldistribution of pediatricians. Third, I will speak to the problem of ensuring quality health care. Last, I will address the financing of graduate medical education and in particular, our concern for continued federal support of Title VII grants.

In the last 50 years the practice of pediatrics has undergone tremendous change due to our success in managing infectious diseases such as tetanus, pertussis, diphtheria, measles and rubella. Where parents used to live in fear of these deadly childhood diseases, parents today have every reason to expect their children to live long and healthy lives. The practice of pediatrics has also changed as a result of new technologies. Increasingly, pediatricians are caring for the special long-term needs of the chronically ill and of children with disabilities. Furthermore, pediatrics has also changed as a result of the dynamic and complex social and familial transformations occurring in society. Now more than ever, pediatricians are called upon to meet the psychosocial and behavioral needs of children and adolescents, issues which demand significantly more treatment time.

As a result of specialized graduate medical training, pediatricians are uniquely qualified to provide the preventive, psychosocial, behavioral, chronic and acute care needed by children and adolescents. Pediatricians receive three years of advanced training explicitly in pediatrics. Those pediatricians who wish to further specialize in neonatology or critical care pediatrics, or pediatric cardiology, nephrology, hematology/oncology, pulmonology, endocrinology, or adolescent medicine train for an additional two or three years.

Supply and Demand Factors in Pediatrics.

Research by the AAP finds that there will be approximately 44,000 general pediatricians by 1990 and 58,000 by the year 2000. This corroborates the predictions made by the Bureau of Health Professions which estimated that there will be 45,000 pediatricians by 1990 and 57,000 by the year 2000. We believe that there are many factors which could mitigate these supply projections, including changes in medical school enrollment, the number of foreign medical graduates and alterations in the size and content of pediatric residency programs. Nevertheless, current data indicate that, similar to the other primary care specialties, the projected aggregate supply of pediatricians is adequate. However, raw national numbers do not tell the whole story.

Experience has demonstrated that, given the state of flux in the health care system, estimating the need for pediatricians is as much an art as a science. It is evident that many factors, which are difficult to assess in terms of their positive or negative impact and magnitude, will influence future numbers of pediatricians. These include the growth of alternative delivery systems, such as HMOs and PPOs; the use of new technologies; the increased demand for more time in parent and patient counseling and anticipatory guidance; complex psychosocial behavioral needs; and the emergence of new chronic or infectious diseases such as AIDs. Even more important may be the impact the emerging adolescent morbidities, such as teen pregnancy, suicide and substance abuse, will have on requirements for pediatricians.

Two examples of pediatrician demand factors which were once assumed would lessen the necessary numbers of pediatricians now apper to be neutral rather than negative influences. These are the growth in the supply of allied health professionals and the increasing number of women entering pediatrics. The contemporary view of the services provided by nurse practitioners and physician assistants is that they are complementary to rather than substitutive for services provided by pediatricians. Although the proportion of women in pediatrics is increasing as projected, it is unclear if their future practice patterns will differ significantly from those of their male counterparts.

Given the uncertainties surrounding pediatric manpower needs, we differ with the COGME's preliminary assessments stating that pediatrics is an oversupplied specialty.

CHILD HEALTH CARE NEEDS/MALDISTRIBUTION OF PEDIATRICIANS

Two principal factors cause us to question the reliability of COGME's conclusions for the long term. These factors are the unmet health care needs of children and adolescents and the maldistribution of pediatricians across the country.

Children constitute the largest age group living in poverty in our nation and the numbers are growing. One-fifth of children live below the federal poverty level; 21 percent live in single-parent households. There are approximately 12 to 16 million children who are uninsured for their health care. Post-neonatal mortality rates have increased and have been increasing for the last several years. The disturbing fact is that these mortality rates are attributed mostly to environmental factors. Eighty percent of these babies were of average birthweights. They simply were unable to get the kind of family and health support in their community they needed to make it to their first birthday.

We live in a nation where the average life span is increasing, while at the same time infants are dying at inordinately high rates. We continue to be a world leader in medical technologies, yet many of our children fail to receive the most basic of preventive health services. At a time when policy makers focus their attention on containing health costs, we are overlooking the millions of children and pregnant women that lack even minimum financial resources to purchase care. But this tide is beginning to turn, albeit slowly. Children's health care needs are emerging as an issue on the national agenda and pediatricians are taking a lead role in this crusade.

The maldistribution of pediatricians in both rural and inner city areas of the country will continue to confound attempts to assess future pediatric manpower requirements. The AAP has undertaken several initiatives to support pediatricians practicing in rural areas. Through grants from the Division of Maternal Child Health and private foundations, Starting Rural Practice workshops have been held at the past five AAP annual scientific meetings. These day long programs have been geared to residents and have highlighted the specifics of rural practice. Also, a network of state rural health coordinators has been developed and materials addressing concerns of rural physicians are being distributed through this network and among residents, medical students and organizations involved in recruiting physicians to rural areas.

We therefore contest any federal policy which would alter the future supply of pediatricians. We recommend that current levels of pediatric residents be maintained until data are found to substantiate either an increase or decrease in the numbers of residents based upon changes in children's health care needs.

QUALITY HEALTH CARE

Steps must be taken to ensure the continued quality of pediatric graduate medical education. We are concerned both about the continued quality of pediatric training programs as well as the quality of individual candidates entering pediatric residency programs.

The goal of pediatric residency education is to produce primary care physicians capable of caring for infants, children and adolescents, performing as advocates for that population, and counseling their families. Each of these functions is a critical role for today's pediatrician and together they constitute a complex set of responsibilities. Pediatric education and the service delivery systems should be responsive to the health needs of children and adolescents. Future pediatricians will be expected to manage both acute and chronic health problems, manage children with emotional disturbances and with disabling conditions, provide counseling for problems that are psychosocial or behavioral in nature, utilize community resources, collaborate with others of the health care team, and, for those in private practice, manage the practice efficiently.

It follows, therefore, that the training for such a profession must reflect these needs. The Residency Review Committee, the body responsible for drafting the special requirements for training, periodically evaluates the minimum requirements and makes changes as needed. As the practice of pediatrics has expanded, so have the requirements.

Increased emphasis on training in ambulatory care has resulted from the recognition that even complex pediatric problems can often be best managed on an ambulatory basis. Furthermore, continuity of care can best be learned through caring for patients on a regular, long-term basis, especially those with chronic disease or with a disability. Ambulatory training also provides an excellent opportunity for residents to learn to cooperate with other caregivers. Such training should include care for acute illnesses, trauma, counseling, anticipatory guidance, planning and managing the long-term care of children with disabilities and chronic conditions, and caring for adolescents. Pediatric residency education increasingly depends on the use of high-quality, non-traditional educational settings, i.e., ambulatory and outpatient clinics, community-based clinics, and private practices. The faculty for such a program must be trained in the delivery of ambulatory care as well as in hospital-based services. Financial support for facuty development is crucial to the success to residency programs.

The pediatrician also must be capable of caring for the severely ill child in the hospital environment, whether that child is a newborn or an older child. Residents must learn the complex processes of treatment and decision-making and how to care for patients requiring multidisciplinary care. Planned, progressive levels of responsibility in such a setting are essential.

Only high caliber candidates should be permitted entrance to pediatric residency programs, regardless of whether they are U.S. or foreign born. We believe that all candidates for pediatric residency programs should take uniform qualifying exams. In addition, foreign trained physicians should undergo clinical and language competency evaluations. Like the Council, we support an international scholars program. Qualified foreign nationals should be allowed to train in the United States, but should be required to return to their home countries where critical shortages of pediatricians frequently exist.

Foreign-trained nonboard-certified physicians (FMGs) are a significant percentage of pediatricians. In 1985, 26 percent of all general pediatricians were foreign medical graduates as compared with 21.5 percent for the total physician population. The disproportionate representation of FMGs in pediatrics will likely continue. Between 1982 and 1984 the proportion of FMGs in pediatric residency programs increased from 24.5 percent to 27.8 percent. In contrast, the proportion of FMGs in the total resident population decreased from 19 percent to 18 percent.

The impact of FMGs on children's and adolescents' care is a concern for pediatrics. The performance of FMGs on the certification examinations administered by the American Board of Pediatrics can be measured. In the 1986 exams, 82 percent of the U.S./Canadian candidates passed the written portion compared with only 32 percent of the FMGs. On the oral examination, 88 percent of the U.S./Canadian candidates passed compared with 65 percent of the FMGs.

The AAP has in previous testimony made several recommendations with regard to FMGs. Since FMGs tend to fill positions in large urban areas rather than in suburban, private practice situations, we do recognize that the withdrawal of residents from the pediatric workforce, especially in inner city areas, will create a manpower shortage in certain hospitals. The Academy has received a contract from the Health Resources and Services Administration (HRSA) to explore alternative arrangements for staffing pediatric services. The Residency Replacement Project will document strategies that have been employed by hospitals to decrease dependency on residents for the staffing of pediatric services without compromising access to and quality of inpatient and ambulatory care. The results of the study will be available in early 1988 and are expected to assist other hospitals in making similar staffing transitions.

The integrity of our pediatric residency programs must be safeguarded. Institutional service needs should not be allowed to determine the size or content of residency programs. Those programs whose principal functions have become the staffing of institutional clinics should be reduced or eliminated.

FINANCING

Finally, I would like to address the financing of graduate medical education. We believe that existing federal, state and private sector funding levels must be maintained. New and innovative ways must be explored to support the increased need to train residents in ambulatory settings (such as outpatient clinics, physicians' offices, or HMOs) as well as in traditional inpatient settings. This funding should be provided up to and beyond primary board eligibility.

Furthermore, Title VII, the Health Professions Training Assistance Act, funding should be continued and augmented so that more pediatric residency programs may benefit. This funding is critical in light of the increased need to train pediatricians in community settings and in the care of children and adolescents with behavioral and psychosocial problems. The creativity allowed by this program has enabled residency programs to use non-traditional sites and to encourage pediatricians to practice in underserved areas. Decreases in this funding would impair the ability of existing programs to continue this aspect.

COGME's Subcommittee on Graduate Medical Education Programs and Financing recognized the dilemma surrounding the need for ambulatory care training and the lack of sufficient financial support. We applaud that subcommittee's recommendation that primary care training requires the use of ambulatory and other non-traditional sites and that federal and state support for such training programs must be, at a minimum, maintained.

In summary, we believe that federal manpower policies should not place children's future access to health care at risk, particularly when history has demonstrated that manpower predictions are based upon assumptions that invariably change over time. We ask that COGME:

1) Reconsider its manpower supply conclusions with regard to pediatrics,

2) Maintain current levels of pediatric residents until hard data can substantiate changes based upon evolving child health care needs,

3) Ensure the continued quality of pediatric graduate medical education both in the content of contemporary training programs and in the quality of candidates for these programs, including those that are foreign trained.

4) Continue financial support of pediatric residency programs, particularly Title VII grants.

We look forward to continuing to work with this panel and are ready to supply further information at your request.

STATEMENT
of the
AMERICAN COLLEGE OF PHYSICIANS
Submitted to the
COUNCIL ON GRADUATE MEDICAL EDUCATION

November 20, 1987

The American College of Physicians (ACP) is pleased to have this opportunity to appear before you today to present our views on a number of issues concerning graduate medical education. I am Lawrence Scherr, M.D., F.A.C.P., President of the College.

The College represents over 65,000 doctors of internal medicine, subspecialists, and physicians-in-training. Our membership includes private practitioners delivering primary health care; medical specialists in such fields as gastroenterology, endocrinology, oncology, and cardiology; medical educators; and researchers. Since its inception in 1915, the College has sought to uphold high standards in medical education, medical practice, and medical research.

For more than a decade, the American College of Physicians has expressed concern about an impending oversupply of physicians. The College, aware of the high costs required to educate and train each physician and the large public subsidy involved, believes that the nation can ill afford to continue building an aggregate surplus of physicians. Instead, ways must be found to better distribute physician manpower among medical specialties and across geographic areas. A national policy is needed that will assure adequate funding for graduate medical education, and that will help to better match health manpower supply with national health care needs.

We believe that this Council, with its 10-year charter to study policy issues related to the supply and distribution of physicians and to advise the Secretary of HHS, as well as to make recommendations to specific committees of Congress, has a unique opportunity to facilitate the development of a much needed, coherent, comprehensive, national health manpower policy. We commend the Council for beginning its task by identifying the principles that will underlie its future recommendations. We would like to highlight a few of those principles, which we understand are being considered for inclusion in the Council's first report.

CoGME PRINCIPLES

The American College of Physicians agrees whole heartedly that, "The primary concern of the Council must be the health of the American people," and that, "There must be assured access for all to quality medical care." We further concur with the principle that, "The quality of medical care as well as the adequacy of the supply of physicians are products of the medical education system. Hence, assurance of access to good care requires the assurance of sufficient numbers of appropriately educated physicians." We also want to express our agreement with the Council's acknowledgement that there are diverse needs among various geographic areas and segments of the population, and that conclusions and solutions based on averages will often ignore these diverse needs.

Further, we favor the Council's preference for targeted programs to achieve desired goals such as increasing representation of minorities in the health professions. Finally, we wish to commend the Council for recognizing that its recommendations must include an international perspective and must take into account changes in demographics, changes in disease patterns (such as the AIDS epidemic), and changes in patterns of health care delivery (such as increased emphasis on ambulatory care).

We now wish to respond to the request for comments on specific issues being considered by the Council.

PHYSICIAN MANPOWER

Despite substantial changes affecting the organization and delivery of health care and past warnings of a major imbalance between the supply and need for physicians, American medical schools have continued to produce numbers of graduates that are far in excess of national needs. Thus, the nation is faced with an impending surplus of physicians that may substantially exceed the levels predicted by the Graduate Medical Education National Advisory Committee (GMENAC) / 1 in 1980.

Recently, Lewin and Associates, Inc. completed a study / 2 for the Federated Council for Internal Medicine (FCIM) of which the College is an organizational member, that attempted to update the GMENAC projections for Internal Medicine and extend them from 1990 to 2020. Even with adjustments for increasing patient care needs due to the AIDS epidemic, changes in physician productivity by gender, and other adjustments based on more recent data on population growth, the Lewin study shows that the aggregate numbers of physicians in Internal Medicine will continue to show a slight excess each year beyond the levels required, and that the surplus will range from 10-20%. Nevertheless, if current trends continue, increasing shortages will result each year for General Internists, while surpluses will persist for most medical specialists.

We do not agree with the conclusion of the Subcommittee on Physician Manpower that there is no convincing evidence that a physician surplus will lead to socially undesirable consequences. In 1975, 42,303 students applied for admission to US allopathic medical schools. Of these, 15,365, about one-third, were accepted. In 1986, only 28,500 students applied, but approximately 16,000 were accepted. / 3 Thus, in little more than one decade, the chances of being accepted into medical school have increased from 1 in 3, to about 1 out of 1.8. If trends of the past several years persist, by 1992 our medical schools will be accepting 4 out of every 5 applicants. Based on analyses of the aptitude test scores and cumulative grade point averages of the applicants since 1984, such a high acceptance rate will mean reduced average scholastic achievement levels among those who enter medical school. Thus, as medical schools maintain or increase enrollments in the face of a declining applicant pool, the quality of medical school students, as indicated by objective measures of scholastic ability, can be expected to decrease. These trends may seriously jeopardize the quality of future medical care, particularly in light of the inability of the medical marketplace to deter the overprovision of medical services. With regard to the effects of a physician surplus, lessons can be learned from studies that have been made of the experiences of Israel and some of the countries of Western Europe. /4,/5 In addition, serious concerns have been raised about the implications for this country of a physician surplus on the overutilization of medical services. /6-/10

Consequently, we recommend that no new medical schools (allopathic or osteopathic) should be established in the United States, and that no existing schools should increase in terms of class size. We suggest that all allopathic and osteopathic medical schools should participate in a national initiative to achieve an overall reduction in medical school enrollments. However, in no event should there be reductions in enrollments of students from underrepresented minority groups (Blacks, Hispanics and Native Americans).

While we agree with the Manpower Subcommittee's preliminary conclusion that an oversupply of physicians could be potentially beneficial in addressing problems of access, past experience has shown that merely increasing the aggregate supply of physicians will not assure that adequate numbers of physicians are available throughout the United

States or that physicians will be distributed well among the medical specialties. This reality has been recognized by public policymakers since at least the mid-1970s, when Congress realized that after more than a decade of federal health manpower initiatives, problems of geographic and specialty distribution of health professions personnel appeared to have worsened. /11,/12 Congress responded by enacting the Health Professions Educational Assistance Act of 1976 (P.L. 94-4[illegible]4), declaring that an aggregate national shortage of physicians no longer existed and providing incentives to encourage physicians to enter into specialties and to locate their practices in areas where needs were greatest.

This same challenge persists today. Recent estimates by the Robert Wood Johnson Foundation /13, based on a 1986 national survey indicates that [illegible] million Americans consider that they have no physician, clinic, or hospital that is their regular source of medical care." The survey further revealed that, "the equivalent of 38.8 million Americans reported needing health care, but having difficulty obtaining it." Consequently, we do not believe that continuing to generate an excessive supply of physicians in the hopes that some of these physicians will be driven by market forces to locate in underserved areas is an appropriate response to the problems of access.

We believe that Federal health manpower policy should seek to assure access to good quality health care for those who are now medically underserved. We, therefore, support the Subcommittee's recommendations that targeted efforts are still needed to address identified problems such as specialty mix and geographic distribution of physicians, that financial support for medical education should foster training in ambulatory settings, and that incentives should be strengthened to encourage physicians to locate and remain in health manpower shortage areas.

Historically, Blacks, Hispanics and Native Americans have been under-represented in medical schools and in the medical profession relative to their proportion of the total population. Although the proportion of minority medical students from Black and Hispanic groups increased during the period of rapid expansion of medical school enrollments (mid-1960s to the mid-1970s), this progress has eroded during the past decade /14. Between 1975-76 and 1986-87, the proportion of minority applicants rose from 7.2 to 10.2% of all applicants, but the acceptance rate, percent of all acceptees, and the absolute number of first year enrollees for minorities have shown only modest increases. /15,/16

The American College of Physicians believes that there should be equality of opportunity for careers in medicine and that increasing representation of underrepresented minority groups in medical schools and in the profession should be a national goal of high priority. Consequently, we also favor governmental financial assistance programs and medical school enrollment policies to assure that opportunities are available to pursue medical careers for students from minority and economically disadvantaged groups. Even in light of an overall surplus of physicians, federally supported financial assistance will be required to ensure that opportunities for medical careers are not restricted based on family income, and that opportunities are increased for underrepresented minority students. Furthermore, continued federal financial support for the costs of graduate medical education will be necessary to assure that specialty decisions are not dictated by financial considerations.

FOREIGN MEDICAL GRADUATES

Educational programs accredited by the Liaison Committee on Medical Education (LCME) and the American Osteopathic Association (AOA) are the most appropriate means for educating physicians for practice in the United States. In an era of fiscal constraint and growing abundance of physician graduates from accredited medical programs, it is difficult to justify the expenditure of public monies to support either undergraduate medical education at foreign medical schools or US residency training for graduates of such unaccredited schools. However, abrupt withdrawal of all public financial support for FMG residency training could cause severe problems for those teaching hospitals that rely most heavily upon FMGs for the provision of patient care services and the communities they serve. Therefore, we favor a policy of providing US public funds for the support of undergraduate medical education only for accredited programs and a phased elimination of public financial support from patient care revenues for US residency training of graduates of unaccredited foreign medical schools.

Opportunities for appropriate graduate medical education in the United States should be maintained for limited numbers of alien physicians who enter as exchange visitors and who will return to their country of origin upon completion of training. Barriers to entry into graduate medical education for exchange visitor physicians should be modified, and educational experiences for such physicians should be of the highest quality and in disciplines appropriate to practice in the home country. Funding for the residency training of exchange visitors should be from sources other than patient care revenues, including, where possible, sources from the physician's home country. The United States' role in international medical education should also include fostering the development of educational resources in other nations.

There should also be federal financial support for the graduate medical education of refugees who meet all examination and certification requirements for admission to an ACGME-accredited US medical residency training program. All foreign medical graduates, including those who have their own sources of funding, should be required to meet the same standards of medical knowledge in the basic and clinical sciences and possess clinical skills comparable to those required of graduates from schools accredited by the LCME and the AOA.

GRADUATE MEDICAL EDUCATION PROGRAMS AND FINANCING

The Subcommittee on Graduate Medical Education Programs and Financing has identified some of the factors that have eroded the financial support for graduate medical education, and has recommended that changes in financing should be undertaken in an evolutionary manner rather than precipitously. The College agrees with the wisdom of this approach. We wish to emphasize that graduate medical education is fundamentally linked with patient care and for practical purposes is inseparable from patient care. Therefore, patient care revenues should continue to be an appropriate source of funding for GME. Thus, we also support the Subcommittee's recommendation that, "For the time being, payments for direct costs of GME should be continued through existing mechanisms, utilizing current sources, conduits and recipients."

The Subcommittee has also rightly focused on the problem of financing training for primary care and geriatrics, particularly in ambulatory settings. We agree with the proposed recommendations that call for funding of demonstration programs to develop some alternative methods of payment for such training, and for continuation of existing programs of federal and state support. However, we would hope that the Council would go even further to make specific recommendations to encourage graduate medical education in ambulatory settings. We further suggest that the Council review the requirement under the federal Primary Care Training Grant program (Title VII of the Educational Assistance Act) that each resident spend a minimum of 25% of training time providing primary care to a defined panel of patients. This so called "continuity" requirement has been rigidly applied and is a deterent to obtaining federal funding for many primary care training programs. Consideration should be given to reducing this requirement to 20%.

The Subcommittee has called for study of a number of other problems including the unexplained variance in costs among graduate medical education programs, insufficient representation of minorities within the health professions, and the need for a review of the structure and content of undergraduate and graduate medical education. Some of this research is currently underway and is being conducted by the Congressional Budget Office and others. Nevertheless, the College agrees that more research in these areas is needed.

Finally, there is an additional matter that warrants serious attention. The College has maintained for a number of years that decisions on national health manpower policy must be based on sound data upon which we all can have confidence. More recently, as the College and other major Internal Medicine organizations have struggled with our own private sector initiative to update GMENAC data regarding Internal Medicine, we have been reminded that development of accurate manpower data is a complex and difficult task. A national manpower data base should not be dependent solely upon the good faith efforts of the individual specialty societies. Instead, the federal government must be involved in a credible data collection effort that provides some consistency and uniformity. This Council is charged with providing advice and recommendations on the following:

> "(F) deficiencies in, and needs for improvements in, existing data bases concerning the supply and distribution of, and postgraduate training programs for, physicians in the United States and steps that should be taken to eliminate those deficiencies." (CHARTER)

We, therefore, seriously urge that you give attention to this subject and give high priority in the future to the need to develop a national data base.

CONCLUSIONS

A comprehensive national health manpower policy is needed that involves long-range planning and coordination of the supply and specialty distribution of medical manpower. It should address the aggregate size of undergraduate medical school enrollments, the number of graduate residency training positions, as well as the number of foreign medical school graduates permitted entry into the United States. Attention must be given specifically to the problem of how to meet the patient care needs of minority and underserved populations. National goals should be developed not only for the supply and distribution of graduates of United States allopathic medical schools, but also for the numbers of graduates of US osteopathic medical schools and the numbers of graduates of foreign medical schools who are either US citizens or aliens seeking to practice medicine in the United States. Without such a comprehensive and coordinated national physician manpower policy, voluntary cutbacks in US allopathic medical school enrollments will be offset by increases in the numbers of physicians from these other sources.

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The American College of Physicians urges the Council on Graduate Medical Education to take the lead in developing such a policy, and looks forward to working with the Council over the course of its ten year authorization to help solve some of the perplexing problems that have been identified. Thank you. I would be pleased to respond to any questions.

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STATEMENT OF THE AMERICAN COLLEGE OF SURGEONS

to the

COUNCIL ON GRADUATE MEDICAL EDUCATION

Presented by

George L. Jordan, M.D., F.A.C.S.

November 20, 1987

Mr. Chairman and Members of the Council on Graduate Medical Education (COGME), I am George L. Jordan, Jr., M.D., F.A.C.S., professor of surgery at the Baylor School of Medicine in Houston, Texas and a member of the Board of Regents of the American College of Surgeons (ACS). I am pleased to appear before you today on behalf of the College to discuss policies and trends affecting our nation's graduate medical education system.

ACS is a voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and enhancing the quality of care provided to surgical patients. For nearly 75 years, ACS has provided educational programs for its Fellows, who now number more than 50,000, and other surgeons in this country and throughout the world. The College establishes standards of practice, disseminates medical knowledge, and provides information to the general public.

ACS agrees with COGME's general principles that the health of the American people and their access to quality medical care are primary concerns. We believe these interests are best served by assuring an adequate number of both generalists and specialists to meet patient demands.

Financing Issues

Federal programs of financial support for medical education have significantly improved access to care and have contributed to the worldwide preeminence of American medicine and surgery. It is important to stress, however, that because of its profound influence the federal government must be extremely cautious in executing broad changes in its policy of financing graduate medical education.

For example, reductions in the length of time for which the government will provide direct support for educational costs could impose a severe financial burden on our nation's teaching hospitals and have serious implications for the quality of physician training programs. The number of residency years needed to educate and train surgeons has been determined by educators in each surgical specialty and is under constant review by Residency Review Committees in light of changing technology and clinical advances. An effort to reduce the number of years for education and training in general surgery was once attempted, but it was clearly recognized that individuals completing such programs did not perform as well on American Board of Surgery examinations and were considered less competent by their program directors. Consequently, this attempt to reduce the training period for general surgery was abandoned in order to maintain an output of competent, qualified surgeons. It is the College's view that the debate over financing graduate medical education should not be allowed to lower the educational requirements for qualified surgeons, since the public is not well served by surgeons whose training is based on criteria other than educational requirements.

Reductions in financial support for graduate medical education could also have adverse consequences for certain segments of the population. As

COGME has recognized in its principles, physician-to-population ratios often mask the diverse needs of particular geographic areas and disadvantaged groups. Surgeons in training constitute a priceless national resource that assures future high quality health care for all Americans. Moreover, surgeons in training, although not substituting for fully educated surgeons, presently contribute to the clinical care that is provided in teaching hospitals.

The College recognizes that decreased financial support for residency programs could hinder access of minorities and the economically disadvantaged to graduate medical education. These individuals are known to incur larger medical school debts. Consequently, lower stipends or the imposition of tuition fees could cause the financial burden of specialist training to become so high that the underrepresentation of minorities in some specialties would be exacerbated. This is especially true for many of the surgical specialties, which often have extended residency requirements.

Finally, before recommending any broad, across-the-board policy changes that could affect aggregate physician supply, COGME must consider their potential impact on specialties composed of relatively few physicians. Some of these specialties are just developing because of technological advances (e.g., Interventional Radiology); others are expanding as a result of newly identified needs (e.g., Aerospace Medicine and Occupational Medicine). In any event, the nation's health and access to care would not be served by policies which indiscriminately reduce the number of physicians across-the-board regardless of specialty.

Manpower Issues

Access to quality health care can only be assured if our nation's medical education system trains sufficient numbers of both generalists and specialists. ACS recognizes that special public policies may be needed to address specific physician manpower problems.

There have been projections of an impending oversupply of physicians. In particular, studies conducted years ago by the Graduate Medical Education National Advisory Committee (GMENAC) forecast an oversupply of specialists and an undersupply of primary care physicians. ACS believes strongly that these projections are grossly oversimplified and that they do not reflect the complicated patterns of today's health care delivery system.

According to the ACS Longitudinal Study of Surgical Residents, which represents the most complete source of surgical resident data in the United States, the number of surgical residents in training shows no sign of increasing. In fact, the total number of surgical residents would have to increase by 18.6 percent to reach GMENAC's projection of 17,000 surgical residents by 1990. Given current trends, it is likely that the difference between GMENAC's projections and the actual number of surgical residents will increase. As in the past, the College would be pleased to continue to share with COGME the information provided by this comprehensive, ongoing study, which is currently in its sixth year.

The College proposes that, for the purposes of assessing manpower supply and demand, the concept of "primary care" either be more clearly defined or dropped as a manpower designation. When the primary care designation was first used about two decades ago, one of the principal assumptions was that such care would be provided almost exclusively in ambulatory settings, and thus be less expensive than inpatient care. The current practice of defining only those services provided by general internists, family physicians, and general pediatricians as primary care does not take into account the true nature of care being provided by both generalists and specialists.

Largely because of new medical technologies, today's generalists and specialists are performing a growing number of services historically performed solely by each other. This overlap in the performance of services is compounded by the increased use of non-physician providers to perform many of the duties that were once performed solely by physicians. Consequently, distinctions based on traditional assumptions governing the practice of medicine have become less meaningful and may, in fact, be misleading.

Further, because the databases used to determine the aggregate number of physicians by specialty have not been altered to reflect the multiple categories of work that any given physician performs, counts and therefore supply projections based on these totals are likely to also be misleading. To address these areas and develop accurate supply totals beyond certification the College encourages the development of a physician specialty database that adjusts for the time spent performing professional activities associated within each specialty, i.e., full time equivalents (FTEs).

A more accurate analysis of physician manpower would classify providers into at least three major categories: 1) general internal medicine, family practice, and general pediatrics; 2) surgical specialties; and 3) "other" medical specialties. When these three groups are examined separately, previously unobserved trends and concerns become evident.

Compared to both primary care and "other" specialists, the proportion of the total physician population composed of surgeons has declined over the past 20 years, from 26.1 percent in 1965 to 23.1 percent in 1985. Similarly, the proportion of surgical residents has decreased substantially -- from 40.2 percent of all filled residency positions in 1969-70 to 26.5 percent in 1986-87. By contrast, the percentage of residents in the primary care specialties increased from 25.5 percent to 40.6 percent in the same period.

Several features of graduate medical education are different for the surgical specialties than for the other specialties. First, there are unique limiting factors on the number of surgeons educated each year. Unlike other specialties, the Residency Review Committees for surgical specialties establish the number of training positions based on clinical volume and the quality of the training program. Thus, the number of surgeons certified by their respective specialty boards has remained constant, or declined slightly in recent years. In a given year, the Surgical Specialty Boards will not accept for examination a number of candidates from each training program that exceeds this approved number. Specialties in general, other than surgical ones, have not used specific criteria such as case volume, clinical resources, etc., to determine the number of trainees

The College also wishes to stress the importance of disaggregating, or examining individually, the specialties that compose the broad manpower category of "surgical specialties". A variety of factors influence some specialties more than others. Studies which lack sufficient detail ignore the unique supply and demand factors affecting individual surgical specialties, and thus overlook our population's diverse and changing health care needs.

Finally, the last category of physicians, "other" medical specialists, has been growing most rapidly -- from 30.9 percent of the physician population in 1965 to 41.9 percent in 1985 -- and these physicians now compose the largest of the three physician manpower categories proposed by ACS.

The Changing Environment

The growth of some of these "other" medical specialties illustrates the limits on our ability to predict future physician needs and supply. Our nation's health care system is dynamic and evolving. Factors affecting physician demand include: the supply of foreign medical graduates, the growing number of female physicians and their practice arrangements, the increasing number of non-physician providers and their efforts to expand their scopes of practice, the emergence of alternative delivery systems, advances in technology, the aging population, the health care demands created by changing patterns in the incidence and prevalence of disease, and, of course, changes in methods of financing graduate medical education.

Therefore, in keeping with COGME's principle to take systemwide changes into account, it would appear to us that earlier projections of physician supply should be re-evaluated in terms of the characteristics of today's health care system. Indeed, this may require a total re-evaluation of our nation's manpower needs with regard to the present day system. This is especially true since GMENAC's manpower projections were based on the health care system of a decade ago.

Sharing Our Resources

To preserve our nation's place in medical leadership and to demonstrate its concern for countries with fewer resources, ACS believes that the United States has an obligation to provide education and training for international scholars who will return to their countries of origin to become medical and surgical educators. Federal financial support should be available for graduates of schools approved by the Liaison Committee on Medical Education (LCME), as well as for a limited number of specially talented graduates from non-LCME approved schools whose abilities are comparable to graduates of American medical schools.

Conclusion

The United States medical education and research systems, and the quality of our health care, are respected throughout the world. To preserve our excellence, this Council and the Congress must maintain a high level of commitment to the quality of the training our physicians receive. In its efforts to control costs and promote the efficient use of valuable health care resources, it is crucial that COGME remain sensitive to changing patient needs and the potential adverse impact of any policies it may recommend. Reduced funding of graduate medical education, while attractive for immediate budget savings, may, in fact, increase total health care costs, since it is unlikely that less capable physicians will be able to practice medicine and surgery in as cost effective a manner.

Mr. Chairman and COGME members, this concludes my formal presentation. The College stands ready to provide any assistance you may require as you review the important issues in your charge, and I would be pleased to answer any questions you may have.

Thank you.

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Mr. Chairman and members of the Council,

I am Fred Featherstone, M.D., Deputy Executive Director of the American Academy of Orthopaedic Surgeons. The Academy appreciates this opportunity to share its views with you regarding the important matters of physician manpower and graduate medical education.

One of the primary objectives of the Academy, as the voice for over 12,000 Board certified fellows, is to assure that patients have access to the best orthopaedic care possible. As such, we view the nation's graduate medical education system as a priceless national resource. It is to the health care system the equivalent of industry's investment in research and development and in capital facilities and technology.

The COGME general principles and reports of its three subcommittees were reviewed recently by a multi-organizational orthopaedic group convened by the Academy. This group, the Council on Orthopaedic Graduate Medical Education, has representatives from the Academy, the American Board of Orthopaedic Surgery, the Residency Review Committee for Orthopaedic Surgery, the Association of Orthopaedic Chairman, the American Orthopaedic Association, and the Council of Musculoskeletal Specialty Societies. On behalf of the orthopaedic community, we wish to compliment COGME on its statement of principles which we agree with in general and on the open and thoughtful manner with which it is approaching its charter charges.

We urge COGME to keep the principles visible and to use them as a litmus test for recommendations as they emerge from your subcommittees and as you frame your reports to the Congress. It would be easy to set them aside, as a task completed, and to ignore them in the pressure to fulfill one or another professional or political agenda that may emerge. In particular, the important principles 9 and 10 get to the heart of a quality and relevant health care delivery system capable of keeping American medicine in the forefront. For medical care in the next century will be only as good as the manpower we produce today -- with in depth knowledge, special technical skills, adaptability and the capabilities of implementing the enormous technological and scientific advances that our biomedical research effort will deliver.

It has taken this nation close to a hundred years and consumed the energies of thousands of educators, physicians, and policymakers to construct our undergraduate and graduate medical education system. It was not a mindless evolution but one compelled by the emerging sciences of medicine and the environments in which it is practiced. This evolution is continuing today. With this in mind, we strongly support principle 5, but believe that only when comprehensive and valid data are analyzed, discussed and debated with the private sector should the Federal Government attempt to intervene or attempt to influence specialty mix and geographic distribution of physician manpower. There is evidence that market forces, as they have in the past, are influencing the medical education/medical practice equation. Decline in medical school applications, shifts of interest in specialty choice away from perceived "over-supply" or "overly competitive" specialties into areas previously less popular for U.S. medical graduates are occurring.

Access to health care is being influenced by the emerging forms of "managed care" systems: such as HMO's with their multiple satellites; IPA's; hospital ambulatory care networks; and a variety of competitive medical plans. Furthermore, there is some evidence, and certainly a widely held perception, that a geographic redistribution of manpower is occurring with an increasing number of smaller communities attracting physicians of all types. The current system is dynamic, evolution is occurring, for there are many forces at work and a lot is happening out there. We should be patient and be sure that our actions do no harm. The Academy is currently studying these trends and should have data for orthopaedics in late 1988.

There is another dimension of the access issue which relates to the availability and characteristics of the professional entry point for first contact care -- primary care -- and follow-up care. While it might be simplier or convenient to ignore the actual and logical contribution which surgical and medical specialists make to the initial care or primary care equation, it would be unwise to do so. With an increasingly educated population, patients as informed consumers can, do, and should select their entry point into the health care system and their sources of continuing care. Patients more often than not make wise choices. The sum of all this type of specialty care is often overlooked by the policy analysts and policymakers.

The orthopaedic community is sensitive to COGME concerns regarding the overall costs of GME, the relationship of service to education, and the content and length of specialty training. However, the constituted bodies of organized medicine have the responsibility to assure the highest quality educational experience necessary to provide the nation with competent skilled specialists. The American Board of Medical Specialties and the Advisory Council on Graduate Medical Education should have the authority to control the content of and length of residency education rather than any single entity. We agree that educational quality should not be compromised by a high volume of services. In fact, the Residency Review Committee for Orthopaedic Surgery documented that the most common reason for probation was the negative impact of excessive service demands on the education environment.

Orthopaedic surgery is an extremely broad specialty. Musuloskeletal complaints and disorders are the most frequent cause of ambulatory physician visits and among the most common hospital discharge diagnoses. The specialty includes primary, secondary, and tertiary care in ways that few other specialties do. Orthopaedists treat children, active adults, and the aged. Their practices blend medical musculoskeletal care with surgical care in approximately equal proportions, with half their practice being office patient care. Estimates of surgical to nonsurgical patient encounters range from 1:10 to 1:20 for 85% of all orthopaedists who declare themselves as general orthopaedic surgeons.

Advances in the management of degenerative joint disease, joint replacement, arthroscopic diagnostic and surgical treatment for internal joint disease and trauma, and advances in spine surgery all have revolutionized the specialty of orthopaedics in the last 30 years. These advances have significantly altered the practice of, and demand for, orthopaedic specialty care. What of the future?

- As our population ages, a concomitant increase in fractures and degenerative disease will occur -- increasing demand for medical and surgical care of musculoskeletal disorders. New knowledge and technology will emerge.

- Changes in the health care delivery system such as:

  - new technology
  - demand for lower length of hospital stay
  - increased use of ambulatory surgical facilities
  - the requirement that the history and physical and other laboratory work up be performed in an ambulatory setting prior to surgical admission

  will place additional stress on the educator, the resident and the curriculum content.

Our society must ensure that adequate resources are available to support the total educational experience wherever it is conducted, i.e., in-hospital or an ambulatory setting.

COGME has a unique opportunity. It could be a strong advocate for the finest graduate education system in the world. It can be an organized point in the policy process which emphasizes and defends quality -- the positives in our system. It has the opportunity by virtue of its charter to take the long and scholarly view and not fall victim to the quick fix syndrome.

We in the orthopaedic community are prepared to assist you in your deliberations and to provide you with such information we may have that would be helpful.

Average Percentage of Cases Treated
Based on Anatomical Site,
Disease Category and Age of Patient

Anatomical Site	Percentage of Cases Mean
Knee/Leg	21.7
Thoracic/Lumbar Spine	18.1
Pelvis/Hip/Thigh	14.2
Foot/Ankle	12.3
Hand/Forearm	12.0
Shoulder/Elbow	9.7
Neck (Cervical Spine)	7.5
Other Non-localized	3.1
Disease Category	
Trauma	42.3
Degenerative/Rheumatoid	25.7
Congenital Developmental	8.2
Neurological	7.6
Infection	3.6
Other	3.4
Metabolic	2.6
Neoplastic	2.3
Vascular (Circulatory)	2.3
19 years and older	71.0
18 years and younger	28.2

NR = 26

Mr. Chairman and distinguished Council members, I am Carolyn Robinowitz, M.D., Deputy Medical Director of the American Psychiatric Association, a medical specialty society representing more than 34,000 psychiatrists nationwide. In addition to the practice of general and child psychiatry, I have spent much of my career in graduate medical education. I am a Clinical Professor of Psychiatry at George Washington University School of Medicine, Immediate-Past President of the American Board of Psychiatry and Neurology, and former Director of the APA Office of Education.

The nature of psychiatric care and training has changed markedly over the past two decades. Scientific approaches to diagnosis, new forms of psychotherapeutic intervention, and a greater and more specific armamentarium of pharmacologic agents have all resulted in more efficacious, cost-effective treatment which in many cases reduces the use of other medical services. The number and quality of U.S. medical students entering psychiatry has increased, and the stigma associated with psychiatric disorders, although still present, is diminishing. It is ironic that these advances are coupled with current and proposed restraints that can hamper the advances in clinical care. Our trainees are a national resource who can transfer this new knowledge into practice.

My testimony today will focus on three areas: the supply of psychiatrists; financing of graduate medical education; and previously noted issues related to foreign medical graduates.

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Supply of Psychiatrists

For a decade, evidence has shown that psychiatrists are in short supply. Numerous studies including those done by the Heritage Foundation, the Rand Corporation, and the DHHS Report of the Graduate Medical Education National Advisory Committee (GMENAC) have specifically identified both general psychiatry and child psychiatry to be in a condition of national shortage. In fact, the GMENAC report projected a shortage of between 3,900 and 5,900 child psychiatrists and 8,500 general psychiatrists in 1990, and these estimates were based on minimal use of psychiatrists' non-substitutable services. Within this section, an overview of the numbers of psychiatrists including trainees is detailed along with the reasons why additional psychiatrists may be needed in the future.

As of September 1, 1986, there were 209 accredited training programs in general psychiatry and 126 training programs in child psychiatry. There were 4,892 general psychiatry and 602 child psychiatry residents on duty on that date. General psychiatry residents comprised 6.2% of all residents in training. Although the numbers of trainees have increased in recent years, there are still gaps in the care delivery system that lead to a need for additional psychiatrists. In particular, additional trainees are especially needed in and for child psychiatry, geriatric psychiatry, substance abuse disorders, care of the most seriously and chronically mentally ill, and psychiatric research. Psychiatry has actively recruited minorities and women. While 38% of our current residents are female, a recent survey demonstrated that only 1% of senior minority medical students planned to enter psychiatry.

According to AMA and APA projections and data, there are over 34,000 psychiatrists of whom about ten percent self-designate as child psychiatrists. Chronic mental illness accounts for the use of up to 25% of all hospital beds. It is estimated that between 12 and 15%, or 7.5 million to 9.5 million of our approximately 63 million children under age 18 suffer from mental disorders that warrant intervention, but less then 1% receive treatment in a hospital or residential treatment facility and approximately 5% or 2 million receive outpatient mental health treatment. Among the 25 million Americans over age 65, some 15-20%, or 3 to 5 million, have significant mental health problems. Moreover, in 1982, persons over age 65 accounted for just over 10% of the U.S. population, but 17% of deaths by suicide. Despite the mental health needs of the elderly, they receive only 6% of community mental health services and 2% of private psychiatric services. As the number of elderly persons increases so will the needs for services.

Studies based on the needs of the population or current utilization trends have documented the continued undersupply of psychiatrists. One recent article by Yager and Borus, based on one side of a debate, suggested we are training enough or too many psychiatrists. Both some of the data and arguments presented by the authors are flawed. No matter what data are used, evidence indicates that approximately 15% of the population at some point in time will suffer from mental disorders serious enough to warrant psychiatric intervention. There are not enough psychiatrists to meet the multiple needs of the seriously and chronically mentally ill population. Many psychiatric hospitals and ambulatory care settings, including those in the private sector, have difficulty filling psychiatric positions. Access to and demand for psychiatric care has been adversely affected by inadequate reimbursement for service delivery as well as the stigma associated with seeking such care. Psychiatric shortage areas continue to be identified in both rural and urban areas, especially inner cities.

The recruitment of additional trainees in child psychiatry is a top priority. Training of all psychiatrists is labor intensive and takes place primarily in ambulatory settings, but the training of child psychiatrists is even more so. Psychiatrists specializing in the care of children and adolescents must be familiar with neurobiological and neurodevelopmental issues, approaches to prevention, as well as psychosocial, sociocultural, and educational factors.

Individuals with substance abuse disorders, both singly and combined with other mental disorders (dual diagnoses), need complex medical treatment and thus, psychiatric care.

Although the development of physician scientists is a problem for all of medicine, the problem is more acute in psychiatry. NIH studies indicate that researchers need a post residency fellowship of at least two years. Given the massive growth in psychiatric research, funding for research training will have a major impact on the type and quality of care. We must continue to recruit psychiatrists into research careers.

Psychiatrists are the only health or mental health professionals who can bridge and integrate the neurobiological and psychosocial aspects of development and illness. Their evaluative, differential diagnostic, and treatment planning skills cannot be duplicated. No other group of care providers is willing or able to undertake care for the most seriously mentally ill members of our society.

Financing Graduate Medical Education

Since the inception of the Medicare program, the Congress has maintained a strong commitment to financing graduate medical education. As hospitals and the Federal government have faced financial difficulties, the trend has been to finance part of graduate medical education or departmental activities through clinical practice income. If this trend continues, it poses some very difficult dilemmas for all medical educators and for psychiatry in particular. Just as we are at the cutting edge of a new era in the science of understanding mental illness, our teachers and researchers are forced to see more and more patients and possibly neglect both the labor-intensive teaching of psychiatry and their own research.

As one of the lowest paying specialties with a heavy ambulatory focus, the amount of income that psychiatrists can generate from clinical practice is minimal compared to more technologically-oriented specialties. Any attempts to cut back funding for graduate medical education can seriously hinder psychiatry's efforts to recruit top trainees and may add to existing disincentives. Some of these disincentives affect all of medicine, and some are specific to our field. The current medical school graduate is likely to leave school with over $30,000 worth of debt (an increase of over 100% since 1980). In order to meet this debt load, the student may either choose a high paying specialty or may choose to forego subspecialty training in order to begin repaying loans at an earlier date. Thus, some individuals interested in specializing in child or geriatric psychiatry, may avoid subspecialization in order to begin loan repayment earlier. Furthermore, psychiatry is among the lowest paid clinical specialties, in part, because so many psychiatrists work in salaried public sector positions.

In addition to high debt loads, psychiatric trainees are faced with the fact that coverage for psychiatric care is limited and discourages individuals in need from seeking care. For instance, the Medicare program currently reimburses a beneficiary no more than $250 (after copayment) annually for outpatient psychiatric care and inpatient hospitalization in a psychiatric hospital is limited to 190 days per a beneficiary's lifetime. In 1984, only 8% of 300 companies provided coverage for both in- and outpatient psychiatric care equivalent to that for all other physical illnesses. At that time, only 48% of privately insured and employed patients had coverage for inpatient treatment for mental illness equivalent to that for other physical illnesses (down from 58% in 1981) and only 7% (down from 10% in 1981) had outpatient mental health coverage that was the same as for other illnesses.

While budgetary constraints require a reexamination of Medicare's financing of graduate medical education, it is our hope that further disincentives to entry into psychiatry will not be put in place. In fact, we recommend that alternative methods of financing graduate medical education should give special note to trainees who can meet the needs of the population with mental disorders.

Foreign Medical Graduates

APA previously testified before the COGME Subcommittee on Foreign Medical Graduates, and I will briefly summarize our statements. As you know, not enough American medical graduates have entered psychiatry to meet the mental health needs of our population. In addition, our country has a moral obligation and responsibility to support FMG physicians who are currently in the system either by virtue of being residents or in practice. FMGs have also provided a great deal of service, both during and after training, to underserved patients, often from lower income levels, in government hospitals. Any abrupt disruptions to the system would seriously impair service delivery to our most ill patients. Finally, psychiatrists have always felt an obligation to promote international scholarship through the exchange of professors, practitioners, and students, and through the maintainence of a major role in the dissemination of new knowledge.

Summary

In sum, APA appreciates the significant task facing the Council. We are a specialty in short supply and feel that special attention must be paid to the needs of the population who warrant psychiatric intervention. Through scientific advances in the understanding of the physiological bases and concomitants of mental disorders, the stigma associated with these disorders has been reduced. Only if the Federal commitment to financing graduate medical education remains, can the appropriate number of psychiatrists be trained to meet the mental health needs of the population and the special needs of our very young and older populations.

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November 16, 1987

The American Academy of Child and Adolescent Psychiatry appreciates the opportunity to appear at this public hearing and submit information and recommendations to the Council on Graduate Medical Education regarding the status of child and adolescent psychiatry as a medical subspecialty. The forthcoming recommendations of the Council to the Congress and the Executive Branch regarding medicine's subspecialty with the severest personnel needs can influence the scope and direction of our medical education for many years.

I. Shortage of Child and Adolescent Psychiatrists.

Currently, child and adolescent psychiatry finds itself in a difficult position because of the great shortage of professionals in this speciality, the pending removal of support systems that would permit growth, and a prevalence rate for emotional disturbances in children and adolescents of over 11 percent, many of whom are not appropriately identified or treated.

In 1980, the Graduate Medical Education National Advisory Committee concluded that there would be 70,000 more physicians in this country than required in this country by 1990, with most specialties having a surplus of professionals; however, child psychiatry was noted as a subspecialty experiencing the greatest shortage -- a shortage that would likely continue through 1990. In 1980 there were approximately 2500 child and adolescent psychiatrists practicing across the country when the Advisory Committee recommended a range of 8,000 to 10,000 child psychiatrists would be required by 1990. This recommendation was not the original finding through converting service requirements into total professionals needed. That estimate was 26,000 child and adolescent psychiatrists -- an estimate that had to be radically adjusted because of near impossibility of realizing such a number of professionals in the even next 50 years. Even the Advisory Committee's revised recommendation calling for only a three-fold increase was based on a prevalence rate of 8.6, which is much lower than the usually accepted 11.8 percent.

In 1987, the number of child and adolescent psychiatrists is estimated at 4,000. The American Medical Association's most recent distribution tables (1986 edition) show 3,709 non-federal child and adolescent psychiatrists and 74 federal child and adolescent psychiatrists. The major professional activities for these physicians are divided as followes:

2,281 in office-based practice
575 on full-time physician staff
130 involved in medical teaching
246 in administration
309 doing research

The addition of 1500 child and adolescent psychiatrists since 1980 is encouraging, but the need still far outreaches any realistic projection of growth. The number of residents in child psychiatry has grown steadily -- from 537 in 1984, to 580 in 1985, and 602 in 1986 -- with the number of training programs remaining around 123. Ninety-six of the approved training programs are in medical schools and the rest in approved hospitals. Many of the training programs (exact number unknown) are linked to state hospitals to provide additional support to the state staff. The training programs are in 41 states plus the District of Columbia and in two Army base hospitals.

In 1984, the training programs had a capacity to train 665 child psychiatrists, but only 537 residents were in the two year program. With 128 "open" slots, child psychiatry was using only 80 percent of its training slots. This compares with general psychiatry at 91 percent, pediatrics at 96 percent and family practice at 95 percent.

The number of residents has increased to over 600; however, the openings are still greater than the number of trainees. Another secondary influence on the shortage of child and adolescent psychiatrists was revealed when a 1985 survey showed 84 percent of medical schools needing additional faculty for child psychiatry programs. Fifty-one training programs had a total of 80 faculty vacancies. That same survey found that eleven of the medical schools with accredited child psychiatry programs either are or very shortly will be searching for a new "chief" of psychiatry.

In order to ease the shortage of child and adolescent psychiatrists, training in child and adolescent psychiatry must be outlined. Beyond the four years of medical school, child and adolescent psychiatric training requires 1 year of supervised hospital medical training (internship), 3 years of approved residency training in general psychiatry with adults, and 2 years of training in psychiatric work with children, adolescents and their families in an approved residency in child and adolescent psychiatry.

In the general psychiatry training years, the resident achieves competence in the basics of psychiatric work. In the child and adolescent psychiatry residency, the child fellow acquires a thorough knowledge of normal child and family development, as well as psychopathology, and treatment. Special importance is given to disorders that appear in childhood, such as pervasive developmental disorder, learning disability, mental retardation, depression, drug dependency and delinquency. The child psychiatry resident further applies and develops psychiatric skills by treating youngsters and their families.

The evaluation and treatment of inpatients and outpatients is important throughout the residency, with a concentration on delivery of appropriate treatment within the family's financial and psychological means. This training includes supervised experience with children of all ages and from all socioeconomic and cultural backgrounds, in long-term psychodynamic therapy, as well as shorter-term interventions, through individual, conjoint or family treatment. The training with hospitalized children and adolescentss provides the preparation for full hospital admission and treatment privileges.

Having completed the child psychiatry residency and successfully passed the examination in general psychiatry given by the American Board of Psychiatry and Neurology, the child psychiatrist is eligible for certification in the subspecialty of child and adolescent psychiatry. Although these last two examinations are not required for practice, they are further assurance that the child and adolescent psychiatrists who are trained and certified in this way can be expected to diagnose and treat all psychiatric conditions of patients of any age, or refer them for such treatment.

II. Federal Policies Influencing Child and Adolescent Psychiatry.

Three federal programs currently influence the numbers of child and adolescent psychiatrists in the country. Policies supporting the continuation or expansion of these programs can move the specialty away from its shortage status.

The Graduate Medical Education program, which allows direct payments for salaries under Medicare, now includes funding for the fifth year of training, but this fifth year has come under Congressional attack -- after the previous removal of the sixth and seventh years of funding for specialty training. Without the support of the Medicare direct payments, the extended training needed for child and adolescents will become too expensive to choose as a specialty. The fifth year of funding should be supported as a means to encourage more child and adolescent psychiatry trainees.

The National Health Service Corps, within the Health Services and Resources Administration, has provided funding for the training of child and adolescent psychiatrists. And, although proposals to eliminate the Corps have been defeated in recent months, there is another ongoing problem with the distribution of NHSC trained child psychiatrists after training.

It has been reported by NHSC trainees that the placement policies requiring their locating in specific priority sites after training kept them from treating children and adolescents. This waste of specialty training during the four year post-training obligation is of great concern, primarily because there are children and adolescents to be treated in each of the priority areas -- the high priority rural areas, the rural areas near urban centers, and in the urban sites which have an undersupply of physicians. In the past, it has been possible to place child and adolescent psychiatrists in sites where they can practice their specialty by approaching the local officials one-on-one and securing a request for placement from them.

In recent correspondence with the NHSC officials, assurances are given that in the 1987 placement cycle, where there were 96 obligated psychiatrists -- 26 of whom are child psychiatrists, there are 24 child psychiatry sites and 2 sites suitable for either child psychiatry or general psychiatry. The assurance is given that NHSC intends to continue its policy of placing child psychiatrists in their specific field, but since this "policy" is barely into its first cycle, it would be reassuring to be able to provide trainees with the secure knowlege that the battle for placement will not have to be staged every cycle and that they will be able to treat children and adolescents as part of their NHSC obligation.

A final area of concern in the federal support for training child and adolescent psychiatrists is the clinical training program within the National Institute of Mental Health.

The appropriations amounts for clinical training have diminished from over $100 million a few years ago to $15 million in FY 1987. These funds are distributed not just to child psychiatry training programs but to a range of mental health professionals. Currently, NIMH can support only 80 of 200 clinical training grants in the priority area of child and adolescent mental health. Of the $15 million appropriated for clinical training in FY 1987, about $1,976,881 is spent on children's programs, down from $3,051,411 in FY 1986. Of the 1987 funds, child psychiatry received only $840,240 -- enough for a few child faculty development grants.

It should be emphasized that funds supporting training programs in child and adolescent psychiatry are used to support faculty, not individual trainee stipends. While the emphasis of this testimony has been on the need for more trained child and adolescent psychiatrists, this faculty support plays an important part in securing the appropriate education for child and adolescent psychiatrists, as well as having a major multiplier effect in the benefits generated by contributing to the education of mental health professionals through child and adolescent psychiatry faculty members. Support for the NIMH clinical training program's continuence and return to more significant funding would encourage expanded, effective training programs:

- o by attracting and supporting additional treaching faculty,
- o by developing improved and expanded educational programs able to attract new students,
- o by increasing faculty support for minority

programs, and programs with increased emphasis on chronic mental illness,

- by improving consultation/liaison activities with primary care physicians and other mental health professionals,
- by allowing the addition of new programs on day treatment, family therapy, and chronic menal illness.

Loss of support for clinical training would result in:

- decreased services to populations served by subsidized training programs,
- a decrease in the quality and quantity of training,
- a limit to new programs and problems with trainee recruitment,
- a fragmentation of faculty and loss of faculty time for evaluation,
- a fragmentation of faculty and loss of faculty time for evaluation,
- a loss of emphasis on the underserved, children and the aging, with specific losses in outreach programs, and
- a major loss of support when states do not have the encouragement to add their support to clinical training programs. When the federal government provides some assistance for a program, even if the support is a minor part of

the total budget, a state and community are far more willing to share the costs.

Clinical training support is an investment whose benefits can be multipled with greater Federal support.

III. Support for Federal Funding of Data Gathering for Child and Adolescent Mental Health Care.

In the Office of Technology Assessment's 1986 Background Paper, **Children's Mental Health: Problems and Services**, one of the first conclusions are put forward concerns the need for more data on children's mental health and the services that are available, the needs are explained as follows:

> A major difficulty in development of this background paper and in designing more effective children mental health progrmas was the lack of data on many treatment regimens and service systems. Although NIMH commits approximately 20 percent of its current research budget to children's issues, available dollars have not kept pace with assessments of the funds necessary. Most mental health care interventions are appropriate for evaluation studies -- and most could benefit from the information that research provides. In addition, basic information about the characteristics and utilization of the contemporary mental health service system is not available. The financial savings from a more comprehensive database are potentially enormous; the benefits to children and society of more effective programs are incalculable.

Their analysis suggests several needs related to children's mental illnesses and services: Two specific needs include a, "more informed estimate of the number of children who require mental health services, and a description of the availablility and use of children's mental health services."

IV. Summary of Recommendations.

In summary, the American Academy of Child and Adolescent

Psychiatry urges the Council on Gradate Medical Education to communicate and recommend to the Secretary of the Department of Health and Human Services, the Senate Finance Committee, and the House Energy and Commerce and Ways and Means Committees the following:

1. Child and adolescent psychiatry is not an oversupplied medical subspecialty. It is a subspecialty with a shortage of professionals.
2. Training for child and adolescent psychiatry requires at least five years beyond medical school; therefore, in order to correct the shortage of child and adolescent psychiatrists, support for training programs should be provided by the federal government.
3. Federal support can be encouraged through the continuation of Medicare's direct payment for the fifth year of specialty training under its Graduate Medical Education program.
4. A written National Health Service Corps policy should be adopted requiring the placing of Corps-trained child and adolescent psychiatrists in sites that allow the treating of children and adolescents.
5. The clinical training program through the National Institute of Mental Health should be enhanced so that the unmet needs of psychiatrically ill children and adolescents are adequately addressed.
6. Data collection regarding the prevalence and utilization of psychiatric services by children and adolescents, as well as the availability of those services, should be

begun as soon as possible. Longitudinal studies of the the screening, evaluation, diagnosis and treatment of children have been an ongoing recommendation, and the federal government should assist in the funding. There is little doubt these studies will direct resources toward the treatments that are effective and, thus, cost effective.

Thank you for this opportunity to testify before the Council. If you have any questions or requests regarding these recommendations, please contact the Academy's Central Office.

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Mr. Chairman and Members of the Council, my name is Jacek Franaszek, M.D. I am a board certified emergency physician and currently practice in Chicago, Illinois. I am president-elect of the American College of Emergency Physicians (ACEP), the national specialty society for emergency physicians. The College appreciates having this opportunity to testify on behalf of our membership before this Council on Graduate Medical Education.

Mr. Chairman, we are here today to address three major points:

1. Unlike medicine in the aggregate, emergency medicine is **not** experiencing a surplus of physicians but, is in fact experiencing a severe shortage.

2. Moreover, this shortage will not be reduced through current residency training output and, therefore;

3. National resources must be focused on addressing this shortage.

Please permit me to elaborate.

Less than two decades ago emergency departments in this country were staffed by house officers or physicians who drew their shift to work in what was termed the "pit." Most were ill-equipped to appropriately handle the wide variety of patient problems that presented to the emergency department. Nor were many of these physicians sufficiently trained to stabilize and resuscitate patients who presented with life- and limb-threatening emergencies.

In response to the public demand for more adequate treatment in emergency departments, the specialty of emergency medicine evolved. In 1968 a group of physicians interested in promoting quality patient care in emergency medicine formed the American College of Emergency Physicians. The College grew from 400 members that year to over 11,600 members today. A fundamental goal of the College has always been the provision of excellent emergency care and emergency services to those in need. The College realized that in order for the specialty to grow, and for services to improve, the establishment of training programs was needed. Accordingly, the first residency training program was developed in 1970 at the University of Cincinnati. Today there are 73 programs graduating over 430 residents per year.

The College also supported the formation of the American Board of Emergency Medicine (ABEM) and worked to create a certifying examination for the specialty. That board was officially recognized by the American Board of Medical Specialties (ABMS) in 1979 and emergency medicine became the twenty-third specialty within the house of medicine.

The American College of Emergency Physicians believes that ideally every patient needing emergency care should have the opportunity to be treated by a board certified emergency physician, at least primarily. This belief is shared by the hundreds of hospitals across the nation that advertise monthly for board certified emergency physicians to staff their emergency departments. Many of these positions remain staffed by physicians in other specialties because of the shortage in numbers of adequately prepared emergency physicians. Therefore, the ideal cannot be currently realized. The Graduate Medical Education National Advisory Committee (GMENAC) report of 1980 predicted a shortage of emergency physicians by 1990. Based on these data, data from the American Medical Association Center for Health Policy Research, our own data relative to residency training production, and the number of physicians certified by the American Board of Emergency Medicine, the American College of Emergency Physicians believes the shortage of certified emergency physicians will persist well into the next century.

Parenthetically, the shortage also exists in military medicine, where large numbers of emergency medicine slots remain unfilled. Indeed, it is commonplace for the military to contract with civilian emergency physician groups to provide emergency care to their personnel.

The current demand for board certified emergency physicians is, at the very least, 14,000 physicians (excluding the military's demand for emergency physicians). This demand is illustrated by the following data:

Currently, emergency departments receive approximately 80 million patient visits per year, although this number is probably an underestimate. However, utilizing the figure of 80 million yearly visits and assuming that each physician will see 2.7 patients per hour for an average of 45 hours per week 47 weeks per year, one arrives at the figure of 14,000 physicians. These data are extrapolated from a study conducted for the College by Mathematica Policy Research, Inc. as well as data from the National Opinion Research Corporation. As of September 1987 there were only 5,840 board certified emergency physicians to meet this demand.

When emergency medicine first became a recognized specialty, there were two main routes to becoming credentialed in order to take the board examination: the residency training route and the practice eligible route. The latter consisted of those individuals who had practiced five years in emergency medicine and at least two years of consecutive full time practice in the specialty. In 1988, the practice eligible route to credentialing will cease, thus ending a resource to reduce the manpower shortage in emergency medicine. The discontinuation of the practice eligible route was a condition of becoming a specialty in 1979. After 1988, therefore, the only route to board certification will be residency training.

Given the rate of residency output, the current shortage will only get worse. As mentioned, there are presently 73 residency training programs in the United States producing 430 residency trained graduates per year. Both the number of residency training programs and the number of residents trained per year have remained fairly stable over the past five years despite a continuously rising demand for those slots. Last year over 3,000 applicants competed for 430 open residency slots in emergency medicine. Because academic emergency medicine is a recent development compared to other academic units within the medical school and because the current contemplated reduction of federal funding for graduate medical education, there is no reason to assume that the number of training programs nor the number of positions will grow without necessary support.

The problem of inadequate numbers of residency training slots in emergency medicine is worsened by the fact that there will be an insufficient number of appropriately trained faculty to staff new positions, were they even to exist. The competition for faculty becomes very keen when there is a shortage of certified physicians, and particularly so in the academic sector. Should academia recruit emergency medicine faculty from the private sector, a further manpower shortage will ensue; this despite the use of many emergency medicine programs of specialists in other disciplines to augment their faculty. Those programs which applied for and were denied accreditation by the Residency Review Committee for Emergency Medicine were consistently cited for failing to have a sufficient number of appropriately trained and qualified faculty on their staff.

The current demand far exceeds current supply -- and the demand is ever increasing. Where do old people go when they are sick? Who sees patients when their own physicians are unavailable? Who is required by law and the tenets of their specialty to see patients when no one else will? Who responds to disaster situations? Who provides ambulatory care to many who lack access to it elsewhere? In my own practice I am seeing increasing numbers of obstetrical and other patients in the emergency department who are uninsured and thus have been refused care by alternative providers. Emergency medicine constitutes a fail-safe mechanism for access to the healthcare system for many that otherwise would not have access to it. And this population of patients continues to rise in number.

Although our specialty was started by second career physicians, it is common for first career new generation emergency physicians to diversify their practice. This diversification is taking place in response to clinical services for which there is a great need. Accordingly, it is not unusual for emergency medicine, though predominately practiced in hospital based settings, to extend beyond the hospital setting into ambulatory care facilities, industrial medicine clinics, poison control centers, and sports medicine clinics. Because of its unique 24-hour a day availability, the hallmark of the specialty is to provide patient services such as critical care in addition to staffing the emergency department.

Many emergency physicians are also involved in non-clinical aspects of medicine including hospital administration, teaching, and most particularly medical administration and the instruction of paramedical personnel in the pre-hospital care system.

A large unknown relative to supply is the rate of attrition from the specialty. The American Medical Association predicts that the average attrition rate of physicians in general is roughly 2-3%. It is uncertain whether this figure can be accurately extrapolated to emergency medicine. There are many reasons to believe that it does not. Emergency medicine is a physically demanding specialty that requires long working hours of great intensity. Emergency physicians are constantly facing critical decisions under a great deal of pressure, sometimes without the benefit of complete information about any given patient. Since emergency physicians constantly work different shifts, their circadian rhythms are consistently disrupted. The demands of around the clock practice make a shorter practice lifetime reasonable to assume. With more emergency physicians leaving practice, the demand to replace them will increase. Thus, without sufficient provision for training an adequate number of new emergency physicians, the projected shortage will increase even further.

The American College of Emergency Physicians believes that quality patient care demands that patients be seen by appropriately trained and board certified emergency physicians. Given present trends, the demands for certified emergency physicians will continue to far exceed the supply. Therefore, the American College of Emergency Physicians urges the Council to request that national resources be refocused on creating appropriate training slots to meet this shortage in our specialty. Moreover, the Council is urged to recommend that there be sufficient number of appropriately qualified faculty to train emergency physicians and other physicians in training in ambulatory care in the emergency department setting.

Emergency medicine is a recognized specialty. As with other specialties, emergency medicine requires appropriate residency training to adequately develop the skills necessary to practice competently. Solutions must focus on ways for expanding and promoting quality graduate medical education as a remedy for the current and future shortage of duly qualified emergency physicians.

Mr. Chairman, on behalf of the College and its membership, I appreciate this opportunity to testify before the Council and am prepared to answer any questions.

Thank you.

GOOD MORNING, I AM DR. TERENCE COLLINS, ASSOCIATE PROFESSOR OF COMMUNITY MEDICINE AT THE UNIVERSITY OF FLORIDA. I AM ALSO VICE CHAIRMAN FOR PUBLIC HEALTH AND PREVENTIVE MEDICINE OF THE AMERICAN BOARD OF PREVENTIVE MEDICINE AND CHAIRMAN OF THE RESIDENCY REVIEW COMMITTEE FOR PREVENTIVE MEDICINE. I AM TESTIFYING ON BEHALF OF THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE, THE NATIONAL SPECIALTY SOCIETY FOR THE FIELD.

PREVENTIVE MEDICINE IS UNIQUE AMONG MEDICAL SPECIALTIES BECAUSE OF ITS FOCUS ON GROUPS OF PEOPLE AND ON HEALTH RATHER THAN DISEASE. THE FIELD, WHICH ENCOMPASSES GENERAL PREVENTIVE MEDICINE, PUBLIC HEALTH, OCCUPATIONAL MEDICINE, AND AEROSPACE MEDICINE, IS CHANGING. THE CHANGES REFLECT INCREASING EMPHASIS ON THE DEVELOPMENT OF CLINICAL PREVENTIVE MEDICINE PROGRAMS WITH A STRONG EPIDEMIOLOGIC RESEARCH BASE, STUDENT INTEREST AND MARKET DEMANDS.

PREVENTIVE MEDICINE IS THE SPECIALTY WHICH CAN HAVE THE GREATEST IMPACT ON THE MORBIDITY AND MORTALITY OF OUR NATION AND IS WELL EQUIPPED TO DEAL WITH PRESENT AND FUTURE CHALLENGES SUCH AS AIDS AND MAJOR ENVIRONMENTAL ISSUES. IT IS THE SPECIALTY MOST CLOSELY IDENTIFIED WITH THE PREVENTION OF DISEASE AND THE PROMOTION OF HEALTH AT BOTH THE INDIVIDUAL AND THE POPULATION LEVELS.

THERE ARE 70 TRAINING PROGRAMS IN PREVENTIVE MEDICINE: 29, GENERAL PREVENTIVE MEDICINE; 5, GENERAL PREVENTIVE MEDICINE/PUBLIC HEALTH; 9, PUBLIC HEALTH; 24, OCCUPATIONAL MEDICINE AND 3, AEROSPACE MEDICINE. THE FIRST POSTGRADUATE OR CLINICAL YEAR OF PREVENTIVE MEDICINE TRAINING IS USUALLY OBTAINED IN OTHER PRIMARY CARE/CLINICAL DEPARTMENTS. THE PGY 2 OR ACADEMIC YEAR LEADS TO A MASTER'S OF PUBLIC HEALTH OR EQUIVALENT DEGREE, AND IS INTEGRATED WITH OR

FOLLOWED BY A PRACTICUM YEAR OF TRAINING PROVIDED IN DIFFERENT SETTINGS, DEPENDING ON THE SPECIALTY. PRACTICUM TRAINING INCLUDES BOTH DIDACTIC AND CLINICAL COMPONENTS.

PREVENTIVE MEDICINE CORE DISCIPLINES ARE EPIDEMIOLOGY, BIOSTATISTICS, OCCUPATIONAL AND ENVIRONMENTAL MEDICINE, BEHAVIORAL MEDICINE, HEALTH ADMINISTRATION AND CLINICAL PREVENTIVE MEDICINE.

THE APPROXIMATELY 6,000 PHYSICIAN SPECIALISTS WORKING IN THIS FIELD ARE FOUND IN MANY DIFFERENT SETTINGS WHERE THEY FREQUENTLY OCCUPY LEADERSHIP POSITIONS: IN HEALTH DEPARTMENTS, UNIVERSITIES, GOVERNMENT AGENCIES, INDUSTRY, HEALTH MAINTENANCE ORGANIZATIONS AND CLINICS. THE PROFESSIONAL ACTIVITIES OF MANY PREVENTIVE MEDICINE PHYSICIANS ARE FOCUSED ON AMBULATORY CARE. SURVEYS HAVE SHOWN THAT 70% OF PREVENTIVE MEDICINE PHYSICIANS SPEND AT LEAST SOME TIME PERFORMING CLINICAL ACTIVITIES. IT IS INTERESTING TO NOTE THAT MANY OF THESE SPECIALISTS ARE DOUBLE-BOARDED: ALREADY BOARDED IN A CLINICAL SPECIALTY, THEY HAVE FELT THE NEED TO COMPLEMENT THEIR TRAINING WITH TRAINING AND BOARD CERTIFICATION IN PREVENTIVE MEDICINE. SPECIALISTS IN PREVENTIVE MEDICINE ARE UNIQUELY PREPARED TO PLAY KEY ROLES IN PROVIDING MEDICAL CARE FOR THE INDIGENT, BOTH IN PROGRAM PLANNING, DEVELOPMENT AND EVALUATION AND ALSO IN THE DIRECT PROVISION OF CLINICAL CARE.

THE GMENAC STUDY PREDICTED A 25% SHORTAGE OF PREVENTIVE MEDICINE SPECIALISTS AND DID NOT VIEW PREVENTIVE MEDICINE AS A CLINICAL SPECIALTY. WHEN YOU VIEW PREVENTIVE MEDICINE AS A CLINICAL SPECIALTY, AS I DO, IT IS QUITE CLEAR THAT THE SHORTAGE WILL BE EVEN GREATER. THERE HAS BEEN NO INCREASE IN THE NUMBER OF TRAINING PROGRAMS SINCE

1981, ALTHOUGH THE CHARACTER OF THE PROGRAMS HAS CHANGED WITH MORE EMPHASIS ON CLINICAL ASPECTS AND OCCUPATIONAL MEDICINE. THERE HAS BEEN NO NET INCREASE IN THE NUMBER OF SPECIALISTS CERTIFIED ANNUALLY SINCE 1982 WHEN PUBLIC HEALTH AND GENERAL PREVENTIVE MEDICINE WERE COMBINED INTO A SINGLE EXAMINATION ADMINISTERED BY THE AMERICAN BOARD OF PREVENTIVE MEDICINE. THIS BOARD CERTIFIES ABOUT 150 PHYSICIANS A YEAR. THERE HAS BEEN AN INCREASE IN RESIDENTS FROM 362 IN 1980 TO 511 AS OF SEPTEMBER 1, 1987. THE NUMBER OF QUALIFIED APPLICANTS IS ABOUT FOUR TIMES THE NUMBER OF TRAINING POSITIONS AVAILABLE. FOR RESIDENTS COMPLETING THEIR TRAINING, THE SHORTAGE IS IMMEDIATELY OBVIOUS BECAUSE MULTIPLE EMPLOYMENT OPPORTUNITIES ARE USUALLY AVAILABLE.

AN IMPORTANT AREA OF INTEREST RELATES TO THE EDUCATION OF INTERNATIONAL PHYSICIANS AND PARTICULARLY TO THE INTERNATIONAL MEDICAL SCHOLARS PROGRAM. THE UNITED STATES PROVIDES THE PREMIER TRAINING IN PUBLIC HEALTH AND PREVENTIVE MEDICINE IN THE WORLD. IT IS IN THE BEST INTEREST OF SOCIETY IN GENERAL THAT WE EDUCATE FOREIGN SPECIALISTS TO GO BACK TO WORK IN THEIR COUNTRIES WHERE THE MAJOR HEALTH CARE NEEDS OF THE WORLD HAVE BEEN IDENTIFIED AND WHERE THE SOLUTIONS FALL WITHIN THE SCOPE OF PREVENTIVE MEDICINE. A MECHANISM IS NEEDED TO INCORPORATE INTO OUR TRAINING PROGRAMS THESE INTERNATIONAL PHYSICIANS AND FUNDING MUST BE MADE AVAILABLE. ALTHOUGH, AT TIMES, FUNDING CAN BE PROVIDED BY THE HOME COUNTRY, AREAS OF GREATEST NEED FREQUENTLY HAVE THE FEWEST RESOURCES. ADDITIONALLY, A CERTIFICATION MECHANISM IS NEEDED FOR THESE INDIVIDUALS. WE SHOULD ALSO POINT OUT THAT MANY U.S. PHYSICIANS RECEIVE EXCELLENT TRAINING IN INTERNATIONAL HEALTH THROUGH OUR

PREVENTIVE MEDICINE RESIDENCY PROGRAMS.

THE LAST MAJOR ISSUE I WISH TO ADDRESS RELATES TO FINANCING OF PROGRAMS. THE MAJOR REASON PREVENTIVE MEDICINE RESIDENCY TRAINING HAS NOT EXPANDED IS THE LACK OF STIPENDS FOR RESIDENTS. BECAUSE PREVENTIVE MEDICINE PROGRAMS ARE NOT HOSPITAL-BASED, FUNDING HAS TO BE OBTAINED FROM A VARIETY OF SOURCES AND PIECED TOGETHER TO SUPPORT INDIVIDUAL RESIDENTS. SUPPORT MAY COME FROM FOUNDATIONS, INDUSTRY, THE MILITARY, RESEARCH GRANTS, THE INSTITUTION HOUSING THE PROGRAM, AND STATE AND FEDERAL SOURCES.

PROGRAMS FREQUENTLY PAY THEIR RESIDENTS FROM SEVERAL SOURCES AND INDIVIDUAL RESIDENTS OFTEN DERIVE THEIR INCOME FROM MORE THAN ONE SOURCE. FOR EXAMPLE, A GENERAL PREVENTIVE MEDICINE TRAINING PROGRAM IN CALIFORNIA WHICH RECEIVED MORE THAN 50 APPLICATIONS AND WHICH COULD TRAIN 12 RESIDENTS IF IT HAD STIPENDS AVAILABLE, IS CURRENTLY TRAINING ONLY NINE RESIDENTS. FEDERAL GRANTS PAY FULL STIPENDS FOR TWO RESIDENTS AND 50% OF STIPEND SUPPORT FOR TWO MORE RESIDENTS; INSTITUTIONAL FUNDS FULLY SUPPORT ONE RESIDENT AND PARTIALLY SUPPORT TWO OTHERS; THE NAVY PAYS ONE RESIDENT; A COUNTY CLINIC, ANOTHER; A PRIVATE MEDICAL GROUP, A THIRD, AND RESEARCH GRANTS PAY 70% OF ONE RESIDENT'S INCOME AND 50% OF ANOTHER'S. IN SPITE OF THIS SORT OF CREATIVE, PATCHWORK FINANCING WHICH CHARACTERIZES PROGRAMS THROUGHOUT THE COUNTRY, APPROXIMATELY SEVEN PERCENT OF ALL PREVENTIVE MEDICINE RESIDENTS ARE STILL PAYING THEIR OWN WAY. IN ONE OF OUR LARGEST TRAINING PROGRAMS, 12 OUT OF 29 RESIDENTS HAVE NO STIPEND SUPPORT.

THE STIPENDS, IN MANY CASES, ARE LESS THAN THOSE OFFERED BY THE

OTHER CLINICAL SPECIALTIES. IT IS UNFORTUNATELY NOT UNHEARD OF FOR A PREVENTIVE MEDICINE RESIDENT TO RECEIVE A STIPEND IN THE $10,000 A YEAR RANGE. THE PROBLEM IS COMPOUNDED BECAUSE SOURCES FOR STIPENDS ARE OFTEN UNSTABLE FROM YEAR TO YEAR, MAKING PLANNING DIFFICULT. WHEN ASKED TO ESTIMATE THE NUMBER OF FUNDED SLOTS THEY WILL HAVE AVAILABLE THE FOLLOWING YEAR, RESIDENCY PROGRAM DIRECTORS OFTEN ESTIMATE FEWER THAN THE NUMBER OF CURRENTLY FUNDED SLOTS. THE DIRECTOR OF A GENERAL PREVENTIVE MEDICINE PROGRAM LOCATED IN THE NORTHEAST, WHICH IS TRAINING FIVE RESIDENTS, ECHOES THE CONCERNS OF MANY PROGRAM DIRECTORS WHEN HE SAYS HE ANTICIPATES THAT FUNDING WILL BE AVAILABLE FOR ONLY TWO SLOTS NEXT YEAR. THE PROBLEM IS FURTHER COMPOUNDED BECAUSE FREQUENTLY THERE IS ONLY LIMITED INSTITUTIONAL SUPPORT FOR PREVENTIVE MEDICINE TRAINING PROGRAMS.

THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE STRONGLY RECOMMENDS INCREASED FEDERAL AND STATE SUPPORT FOR ALL PREVENTIVE MEDICINE TRAINING AND EMPHASIZES THAT THE FIRST PRIORITY IN FUNDING MUST BE RESIDENT STIPENDS. IN MANY INSTANCES IT IS IN THE INTEREST OF INDIVIDUAL STATES TO PROVIDE FOR THE EDUCATION OF THESE SPECIALISTS IN ORDER TO MEET THE NEEDS OF THEIR OWN POPULATIONS. THERE IS ALSO A NEED FOR INCREASED INSTITUTIONAL SUPPORT TO BUILD UP THE EDUCATIONAL INFRASTRUCTURE AND FOR INCREASED INVOLVEMENT OF THE PRIVATE SECTOR PARTICULARLY IN THE FIELD OF OCCUPATIONAL MEDICINE. FUNDING FROM ALL SOURCES SHOULD BE CHANNELED TO UNIVERSITIES AND TO STATE GOVERNMENTS WHICH IN TURN WOULD DIRECTLY SUPPORT SCHOOLS OF PUBLIC HEALTH AS WELL AS OTHER SITES WHERE RESIDENCY PROGRAMS ARE OFFERED, SUCH AS SCHOOLS OF MEDICINE AND OCCUPATIONAL SITES OUTSIDE OF SCHOOLS OF PUBLIC HEALTH.

PREVENTIVE MEDICINE IS A SPECIALTY NOT ONLY WITH A DISTINGUISHED HISTORY BUT ALSO WITH AN INCREASINGLY IMPORTANT ROLE TO PLAY NOW AND IN THE FUTURE -- IN ESTABLISHING COST-EFFECTIVE HEALTH CARE PROGRAMS, IN PROVIDING BASIC RESEARCH IN EPIDEMIOLOGY, IN HEALTH PROMOTION, IN PROTECTING THE WORKER, IN PREVENTING DISABILITY, AND IN FACILITATING EARLY DIAGNOSIS AND TREATMENT. THE SPECIALTY IS PREPARING PHYSICIANS TO DEAL WITH THE INCREASINGLY COMPLEX POLITICAL AND SOCIAL HEALTH CARE ISSUES ON WHICH HINGES THE FUTURE HEALTH OF THE PEOPLE OF THE UNITED STATES AND THE WORLD. THANK YOU FOR THE OPPORTUNITY TO MEET WITH YOU THIS MORNING. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS FOLLOWING THE TESTIMONY OF MY COLLEAGUE, DR. MIKE PARKINSON.

GOOD MORNING. I AM MIKE PARKINSON, A SECOND-YEAR PREVENTIVE MEDICINE RESIDENT AT JOHNS HOPKINS AND PRESIDENT OF THE ASSOCIATION OF PREVENTIVE MEDICINE RESIDENTS. APMR IS SUPPORTED JOINTLY BY THE ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE AND THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE. THE ORGANIZATION REPRESENTS PREVENTIVE MEDICINE RESIDENTS BEFORE OTHER EDUCATIONAL AND GOVERNMENTAL BODIES, FOSTERS COMMUNICATION AMONG RESIDENTS AND WITH MEDICAL STUDENTS, AND GENERALLY PROMOTES THE IDEALS INHERENT IN THE FIELD OF PREVENTIVE MEDICINE.

BOTH THE 1980 GMENAC STUDY AND THE 1986 HHS REPORT TO THE PRESIDENT AND CONGRESS ON THE STATUS OF HEALTH PERSONNEL IN THE U.S. PROJECTED A SEVERE SHORTAGE OF PREVENTIVE MEDICINE PHYSICIANS. THE HHS REPORT STATES THAT "THE SHORTAGE OF PHYSICIANS...OPTING FOR ADVANCED PUBLIC HEALTH TRAINING IS A MAJOR ISSUE. THEIR SCIENTIFIC AND TECHNICAL BACKGROUNDS WHEN COUPLED WITH GRADUATE PREPARATION IN THE PUBLIC HEALTH SCIENCES UNIQUELY QUALIFIES THEM FOR LEADERSHIP IN PRACTICE, RESEARCH AND FACULTY ROLES IDENTIFIED AS BEING IN SHORT SUPPLY." (1)

TODAY, I WILL DISCUSS HOW PREVENTIVE MEDICINE RESIDENCIES SPECIFICALLY AND EFFICIENTLY PREPARE PHYSICIANS TO ASSUME THESE CHALLENGING AND CONSTANTLY EXPANDING ROLES. I WILL DISCUSS SOME OF THE POPULATIONS WHICH THESE PROGRAMS SERVE AND REVIEW SOME OF THE DIVERSE ACTIVITIES WHICH PREVENTIVE MEDICINE TRAINED PHYSICIANS ARE ENGAGED IN. I WILL PROVIDE EXAMPLES OF THE TYPES OF POSITIONS THESE YOUNG PROFESSIONALS ASSUME ON THE COMPLETION OF THEIR RESIDENCIES. I WILL OUTLINE THE MAJOR BARRIERS FACING THE MEDICAL STUDENT WHO

SEEKS TO PURSUE SUCH TRAINING. AND FINALLY I WILL ARGUE THAT PREVENTIVE MEDICINE RESIDENCIES, WITH THEIR UNIQUE COMBINATION OF INDIVIDUAL AND COMMUNITY PERSPECTIVE AND SKILLS, REPRESENT AN IMPORTANT, FRONT-LINE RESOURCE IN THE EFFORT TO IMPROVE OUR NATION'S HEALTH.

FAMILY PRACTICE AND EMERGENCY MEDICINE RESIDENCY TRAINING PROGRAMS WERE DEVELOPED AS A RESULT OF MANY DIFFERENT FORCES BOTH WITHIN AND OUTSIDE THE MEDICAL COMMUNITY. THE HAPHAZARD TRAINING OF THE "GP" AND THE "E.R. DOC" WERE CLEARLY INADEQUATE TO MEET INCREASINGLY SOPHISTICATED PUBLIC DEMAND AND DID NOT REFLECT THE BURGEONING BODY OF MEDICAL KNOWLEDGE. SIMILARLY, THE "LAISSEZ-FAIRE" PUBLIC HEALTH DIRECTOR OR "COMPANY DOC" ARE UNFORTUNATE STEREOTYPES OF A BYGONE ERA. THEY ARE BEING REPLACED BY PREVENTIVE MEDICINE SPECIALISTS WHO ARE PREPARED TO DEAL WITH GROWING PUBLIC CONCERN WITH ENVIRONMENTAL AND OCCUPATIONAL RISKS AND EXPANDING LEGISLATIVE AND REGULATORY MANDATES IN THIS ERA OF DIMINSHING FINANCIAL RESOURCES FOR HEALTH CARE. THE INCREASINGLY IMPORTANT DISCIPLINES OF EPIDEMIOLOGY, RISK ASSESSMENT AND CLINICAL PREVENTIVE MEDICINE DEMAND A SYSTEMATIC, INTEGRATED AND PRACTICAL APPROACH TO PHYSICIAN TRAINING. PREVENTIVE MEDICINE RESIDENCIES PROVIDE THAT APPROACH.

PREVENTIVE MEDICINE RESIDENCIES TRAIN PHYSICIANS IN THOSE SITES AND SETTINGS WHICH ARE MOST LIKELY TO SERVE THE TRULY NEEDY OR MOST AT-RISK.

PREVENTIVE MEDICINE TRAINED PHYSICIANS DELIVER PRIMARY CARE IN MANY PUBLIC HEALTH DEPARTMENTS TO THE MEDICALLY INDIGENT, NAMELY, THE UNDER- AND UN-INSURED. A RESIDENT FROM THE UNIVERSITY OF SOUTH CAROLINA PROGRAM NOW DIRECTS A SIX-COUNTY RURAL GEORGIA HEALTH DEPARTMENT AND IS RESPONSIBLE FOR ALL CLINICAL AND ADMINISTRATIVE ACTIVITIES FROM PRENATAL AND PRIMARY CARE TO ENVIRONMENTAL CONCERNS AND THE AIDS SCREENING PROGRAM.

RESIDENTS ARE TRAINED TO CONDUCT DISEASE SURVEILLANCE AND HEALTH EDUCATION PROGRAMS AMONG VULNERABLE POPULATIONS, SUCH AS MIGRANT WORKERS AND PRISONERS. A RECENT GRADUATE FROM THE HOPKINS PROGRAM NOW OVERSEES ALL MEDICAL SERVICES AND MONITORS AIDS, TB AND FOODBORNE ILLNESS FOR THE MARYLAND STATE PENITENTIARY SYSTEM.

RESIDENTS LEARN TO MEASURE COMPLIANCE WITH FEDERAL, STATE AND LOCAL ENVIRONMENTAL AND OCCUPATIONAL HEALTH STATUTES AND EXAMINE WORKERS FOR EVIDENCE OF ADVERSE TOXIC EXPOSURES. ANOTHER HOPKINS GRADUATE NOW WORKS WITH NIOSH IN CINCINNATI INVESTIGATING REPORTED CLUSTERS OF DISEASE AMONG WORKERS IN CERTAIN PLANTS OR INDUSTRIES.

PREVENTIVE MEDICINE RESIDENTS ARE ALSO TRAINED TO CONDUCT RESEARCH AND INCREASINGLY TO TEACH TECHNIQUES OF INDIVIDUAL AND COMMUNITY BEHAVIOR MODIFICATION TO MINIMIZE RISK FACTORS. A RECENT GRADUATE OF STONY BROOK'S PROGRAM IS NOW RESPONSIBLE FOR HEALTH PROMOTION ACTIVITIES AT A PROVIDENCE, R.I., COMMUNITY HEALTH CENTER. SHE ALSO TEACHES PREVENTIVE PRACTICES TO BROWN UNIVERSITY MEDICAL STUDENTS. FULLY 20% OF ALL RECENT OCCUPATIONAL MEDICINE RESIDENTS HAVE ACCEPTED ACADEMIC POSITIONS, A TESTIMONY TO THE DEMAND FOR THIS EXPERTISE IN OUR NATION'S MEDICAL SCHOOLS. (2)

PREVENTIVE MEDICINE TRAINED PHYSICIANS INCREASINGLY PROVIDE LEADERSHIP AT THE HIGHEST LEVELS OF OUR GOVERNMENT IN ARTICULATING

AND IMPLEMENTING INFORMED, SCIENTIFICALLY SOUND POLICIES. A RECENT GRADUATE OF CDC'S PREVENTIVE MEDICINE RESIDENCY PROGRAM NOW DIRECTS THE NATIONAL OFFICE ON SMOKING AND HEALTH.

MANY PHYSICIANS UNDERTAKE FORMAL PREVENTIVE MEDICINE TRAINING AFTER DECIDING THAT ALL TOO OFTEN "CURATIVE" MEDICINE DOESN'T CURE, AND THAT "HIGH TECHNOLOGY FIXES" THAT LEAD OUR NATION TO SPEND DISPROPORTIONATE RESOURCES ON THE FINAL TWO WEEKS OF LIFE IN AN INTENSIVE CARE UNIT ARE INHERENTLY WRONG. MANY HAVE COME TO REALIZE THAT PREVENTIVE PRACTICES, HEALTH EDUCATION, CONTAINMENT OF ENVIRONMENTAL AND OCCUPATIONAL HAZARDS AND SOCIOCULTURAL INFLUENCES ARE OFTEN PRIMARY DETERMINANTS OF WELLNESS AND DISEASE. THESE PHYSICIANS ARE DRAWN TO THE REAL WORLD MIX OF INDIVIDUAL AND POPULATION PERSPECTIVES AND EXPERIENCES WHICH PREVENTIVE MEDICINE TRAINING AND PRACTICE UNIQUELY PROVIDES.

ONE WOULD THINK THAT MEDICAL STUDENTS INTERESTED IN COMBINING THEIR CLINICAL EXPERTISE WITH POPULATION-BASED QUANTITATIVE SKILLS WOULD HAVE LITTLE OR NO PROBLEM DOING SO. IN FACT, THE OPPOSITE IS TRUE. I HAVE RECEIVED NUMEROUS LETTERS FROM STUDENTS WHO FIND IT DIFFICULT TO UNDERTAKE A PREVENTIVE MEDICINE RESIDENCY.

FIRST, THERE IS A DEFINITE SHORTAGE OF ROLE MODELS, OR AT LEAST ROLE MODELS WHO ARE ROUTINELY ACCESSIBLE IN THE MEDICAL SCHOOL SETTING. THE HISTORICAL RIFT BETWEEN CURATIVE MEDICINE AND PREVENTIVE OR PUBLIC HEALTH MEDICINE HAS CREATED A SITUATION WHERE THE SPECIALTY OF PREVENTIVE MEDICINE IS, IN MY EXPERIENCE, RARELY DISCUSSED AS A CAREER OPTION WITH STUDENTS. MANY RESIDENCIES ARE AFFILIATED WITH LOCAL OR STATE HEALTH DEPARTMENTS OR SCHOOLS OF

PUBLIC HEALTH. AS A RESULT, MEDICAL STUDENTS OFTEN HAVE LITTLE OR NO CONTACT WITH PREVENTIVE MEDICINE RESIDENTS. THIS LACK OF ROLE MODEL EXPOSURE IN OUR MEDICAL SCHOOLS IS A MAJOR IMPEDIMENT TO STUDENTS LEARNING ABOUT AND PURSUING THE FIELD.

THE MOST FORMIDABLE OBSTACLE, HOWEVER, IS THE FACT THAT THE MEDICAL STUDENT WHO WISHES TO UNDERTAKE A PREVENTIVE MEDICINE RESIDENCY FACES CONSIDERABLE ECONOMIC UNCERTAINTY AND EVEN HARDSHIP. IN 1987, THE AVERAGE GRADUATING MEDICAL STUDENT WAS $30,000 IN DEBT. (3) PREVENTIVE MEDICINE RESIDENCIES ARE FUNDED FROM FREQUENTLY UNRELIABLE SOURCES, OFTEN AT LEVELS FAR BELOW THOSE OF COMPARABLE RESIDENCIES (IRONICALLY, IN FIELDS ALREADY FOUND TO HAVE AN EXCESS OF PHYSICIANS). MEDIAN SALARIES FOR PREVENTIVE MEDICINE PHYSICIANS ARE IN THE $48,000 RANGE (4); SURELY IT ISN'T THE PROMISE OF AN EXTRAVAGANT INCOME WHICH LURES THE STUDENT INTO PREVENTIVE MEDICINE TRAINING. THE STUDENT DRAWN TO THE INTELLECTUAL EXCITEMENT OF PREVENTIVE MEDICINE OFTEN, UNFORTUNATELY, CONCLUDES THAT HE OR SHE CANNOT AFFORD THE ECONOMIC UNCERTAINTY OF TRAINING.

AS A RESULT OF THESE TWO MAJOR BARRIERS -- LACK OF ROLE MODELS AND LACK OF ADEQUATE FUNDING FOR PREVENTIVE MEDICINE TRAINING -- EVEN THE MOST MOTIVATED STUDENT RARELY SEES THE PREVENTIVE MEDICINE RESIDENCY AS A VIABLE OPTION. YET, FOR OUR FUTURE PUBLIC HEALTH OFFICERS OR OCCUPATIONAL MEDICINE PRACTITIONERS, THESE PROGRAMS REPRESENT THE MOST EFFICIENT, TARGETED AND INTELLECTUALLY SOUND TRAINING ROUTE.

HISTORICALLY, THERE HAS BEEN LITTLE CONNECTION BETWEEN THE NEED FOR TYPES OF MEDICAL SPECIALISTS, RESIDENCY TRAINING PROGRAMS, AND MEDICAL SCHOOL COUNSELLING REGARDING CAREER CHOICES. CLEARLY, PREVENTIVE MEDICINE SUFFERS ON ALL COUNTS. A WELL-DEFINED AND GROWING NEED FOR THESE UNIQUELY QUALIFIED HEALTH PROFESSIONALS HAS NOT BEEN TRANSLATED INTO ADEQUATE (NO LESS EXPANDED) RESIDENCY SUPPORT. MEDICAL STUDENTS, DUE TO INSUFFICIENT RESOURCES AND LACK OF EXPOSURE TO ROLE MODELS. ARE NOT ENCOURAGED TO UNDERTAKE AND DO NOT PURSUE SUCH TRAINING, AND, AS A RESULT, NATIONAL HEALTH NEEDS THREATEN TO GO UNMET.

AS SCARCER RESOURCES DEMAND THE BEST HEALTH RETURN FOR OUR NATION'S INVESTMENT, PREVENTIVE MEDICINE RESIDENCY-TRAINED PHYSICIANS WILL BE CALLED UPON TO APPLY THE CONCEPTS OF ATTRIBUTABLE RISK AND RISK ASSESSMENT TO THE DIFFICULT CHOICES WE WILL UNDOUBTEDLY FACE. DECIDING WHERE TO ALLOCATE RESOURCES: WHETHER TO REDUCE THE AIDS EDUCATION PROGRAM OR EXPAND PRENATAL SCREENING, WHETHER TO CUT BACK ON RADON AND ASBESTOS MONITORING OR INCREASE MOBILE MAMMOGRAPHY UNITS -- THESE ARE THE PROBLEMATIC DECISIONS WHICH THESE PHYSICIANS WILL TACKLE, COMBINING THEIR SKILLS AS PRACTITIONERS, EPIDEMIOLOGISTS AND PLANNERS.

WHETHER WORKING IN GOVERNMENT, PRIVATE INDUSTRY OR ACADEMIA, PREVENTIVE MEDICINE SPECIALISTS HAVE AS THEIR PRIMARY FOCUS THE PRESERVATION AND PROMOTION OF OUR NATION'S HEALTH. IF THE OLD ADAGE "PREVENTION IS BETTER THAN CURE" IS EVER TO BECOME MORE THAN ATTRACTIVE RHETORIC, PREVENTIVE MEDICINE RESIDENCES MUST BE MADE A VIABLE OPTION FOR THOSE HIGHLY MOTIVATED PHYSICIANS WHOSE HEARTS AND MINDS ARE DECIDEDLY IN THE RIGHT PLACE.

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American College of Cardiology

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Statement of the American College of Cardiology
Before The
Council on Graduate Medical Education
November 20, 1987

The American College of Cardiology (ACC) is actively concerned with issues related to medical manpower and welcomes this opportunity to share with the Council on Graduate Medical Education our experiences and activities that may be of assistance. The mission of the American College of Cardiology is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and formulation of health care policy. We believe that access to care, quality of care, and graduate medical education are inextricably linked and all essential to the continued excellence of this nation's health care system.

While health manpower is an unusually complex subject that will benefit from multiple perspectives, we believe our efforts as a professional society, representing 16,000 members who are expert in the provision of cardiovascular medical care, can contribute to the Council's deliberations. The ACC is pleased to announce the forthcoming availability of a new report on manpower in cardiology. As in the past, the College has initiated a lengthy planning process, including the appointment of a Steering Committee and six task forces to prepare for a major meeting, entitled a Bethesda Conference, which was held October 15 and 16, 1987. The objectives of this Conference were to 1) assess the roles of cardiovascular specialists, 2) give guidance to the community regarding quality of care, 3) develop a posture to react effectively to changing needs, and 4) develop an information base for long-range actions. Although the report of Bethesda Conference #19: "Trends in Cardiology; Implications for Manpower" has yet to undergo the formal approval process, once the report is available, we will be pleased to provide copies to the Council for use in assessing our nation's physician manpower needs.

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SUMMARY OF
AMERICAN COLLEGE OF GASTROENTEROLOGY TESTIMONY
BEFORE THE
COUNCIL ON GRADUATE MEDICAL EDUCATION

- The American College of Gastroenterology wholeheartedly agrees that the primary concern of all participants in the health care system should be the assurance of quality health care.

- In response to GMENAC, the federal government has made enormous cuts in its support for graduate medical education. Further cuts would seriously threaten the nation's medical education system.

- Federal policymakers are currently examining options for reforming the Medicare physician payment system to make it more competitive and cost sensitive. This will increase the degree to which the medical system is responsive to the marketplace laws of supply and demand in shaping the size and specialty mix of the nation's physician population.

- Attempts to predict the need for physicians, whether in the aggregate or in terms of specialty training, are very difficult since it is impossible to forecast all relevant factors. If a new system which is truly market responsive, can be designed, there will be little need for artificial manipulation of the system.

* GME should be supported through patient revenues and should be provided in all appropriate settings, including non-inpatient settings.

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TESTIMONY TO COUNCIL ON GRADUATE MEDICAL EDUCATION
SUBCOMMITTEE ON FOREIGN MEDICAL GRADUATES
October 5, 1987

I, Dr. Navin Shah, am here to testify on behalf of the Alliance of Foreign Medical Graduates, as their Co-chairman.

There are 1,200 medical schools (including 127 United States medical schools) all over the world. ECFMG has issued passing certificates to 130,000 FMG's belonging to 900 medical schools from 80 different nations. Due to unavailability of a central body to judge the standards of all schools in the light of U.S. requirements, ECFMG examination created a way to select FMG's to serve American people. This examination also included English language testing. As America needed to supplement their medical manpower, FMG's from all over the world came to U.S.A. after successfully completing the ECFMG examination. They competed for residency slots and some of the lucky ones who got it, were given American post graduate training. After completing the training successfully, they appeared and passed license examination. Most of the FMG's were graduates of well established medical schools while some were from specially created medical schools which catered for American market.

Presently 120,000 FMG's (21.8% of the total number of physicians in U.S.A.) are in practice of medicine. They have taken U.S. post graduate training and achieved license to practice. Over a period of 25 years FMG's have served their co-citizens and they have an excellent verifiable record. Six FMG's earned Nobel prize in Medicine for U.S.A., 20% of the medical teachers are FMG's in U.S.A., 6000 FMG's are in field of research and 80% of FMG's are in direct patient care. FMG's have and are serving areas which attracted few American medical graduates - the inner city hospitals, psychiatric institutions, small county hospitals, VA Hospitals - and helped less fortunate citizens. Some studies have shown: 1) FMG and USMG as professional, are equal, 2) compared to their numbers, less percentage of FMG's are involved in malpractice and have paid less number of dollars in malpractice verdicts, 3) less number of FMG's are disciplined by state bodies. So, in short, FMG's have served and served well.

In last 5 years due to various known and unknown factors there are distinct attempts by some to discredit FMG's as second rate medical practitioners. Presently 16% of U.S. residencies are manned by both USFMG's and Alien FMG's. Of 4452 recognized teaching programs 185 have 100% of their residents from foreign medical schools, while 1115 have between 21 and 99%, 1100 have

have less than 20%. New York City hospitals have 40% and state of New Jersey has 60% FMG's manning their residency. Approximately 30 to 40% of residency slots in Neonatology, Nuclear Medicine, Pathology, Nephrology, Public Health are filled by FMG's. American medical system needs FMG's. They go through entrance examination, post graduate training and license examinatoin, which is totally controlled by American institution. If some feel that FMG's are not adequately trained then it is the fault of American system and not of FMG, who is doing all what is told to do. Discrimination to FMG's in training and to FMG's in practice is a reality. For this reason Alliance of FMG's (group of large number of practicing FMG's) have just introduced two Bills in Congress to do away with discrimination and achieve duely earned equality.

We feel that it is very difficult and almost impractical to attempt to accredit medical schools all over the world. The most pragmatic way would be to accredit each and every FMG who is entering American medical system. This will do away with present 2 tier system and will treat FMG's fairly. We propose:

1) All FMG's take National boards as taken by American medical students - i.e., one test for all medical graduates.

2) All FMG's must pass English examination.

3) After achieving #1 and 2, FMG competes and enter into post graduate training - year one. During this year FMG will be judged on all aspects of medicine and English language. Once the FMG has been qualified he/she enters further years of training.

4) American Residency system to ensure that all teaching programs are of similar quality.

5) Those FMG's who are unsuccessful in the first year will be removed of the system and a central body keeps the data so that FMG is not part of any training program in future.

6) Once FMG completes training he gets license in the same fashion as an USMG.

7) Once FMG gets license he/she should be treated exactly as an USMG is treated in practice of medicine, hospital privileges and reciprocity.

By this mechanism, all doctors in U.S. training and in practice are treated equal. If there is a need for reduction in number of training slots, it should be done across the board and not selectively eliminating FMG's.

Presently there is a scarcity of medical doctors in rural areas, in addition with increasing aging population, advent of deadly disease AIDS, increasing drug abuse and other iatrogenic maladies, America will need more doctors. In 1986, out of 20500 residency 1600 were filled by USMG and 2200 by both USFMG and Alien FMG's and almost 2300 slots were unfilled. In 1985, 6000 qualified FMG's could not enter training programs and it is estimated that almost 10000 qualified FMG's are waiting, since 1 to 5 years, to get into training programs. We believe it is sheer waste of medical talent. One of the many suggestions is to offer them training in needed specialty with a contractual obligation to serve in particular needed geographical area for a period of 3 to 5 years. This way both the purposes will be served fruitfully.

We strongly believe that it will be unwise, costly and possibly harmful to replace FMG's by PA's. A 2 year trained medical person is a poor replacement for totally trained doctor in the medical service. This way superb American medical system will not reach all the patients and especially not to the less fortunates. PA's 8 hour shift, constant medical supervision and negligible help in ICU/CCU will not only prove costly but perhaps dangerous to patient's health.

In these days of spiraling malpractice premiums, replacing doctors with PA may worsen the already bad situations. I, as a doctor and American citizen feel that, American citizens deserve the best possible for their medical care.

Finally, a word about U.S.A.'s obligation to developing and underdeveloped nations. We feel 1000 training slots be created to train FMG's in all different medical specialities and these slots to be located in U.S. geographical areas where there is need for doctors. This is to be funded by foreign aid. It will consume less than 1% of present foreign aid packet. These trained FMG's will go back to their country. They will not be allowed to appear for license examination and hence can not practice in U.S.A. Faultering FMG's will be deported.

Lastly, a request to this body to contact me in matters of FMG's for Alliance involvement and input.

Thank you for your patient hearing.

Navin Shah, M.D.
Co-Chairman
Alliance Foreign Medical Graduates

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TO: Council on Graduate Medical Education

FROM: American Academy of Physical Medicine and Rehabilitation
"Physical Medicine and Rehabilitation: Manpower Needs"

The goal of the specialist in physical medicine and rehabilitation (physiatrist) is to optimally restore physical function, relieve pain, and mimimize te psychological, social and vocational sequelae of disability. Physiatrists use the routine history and physical examination, x-rays, laboratory studies and other diagnostic techniques like other physicians, but also frequently prescribes such treatment modalities as heat, cold, electrical stimulations and biofeedback. Special types of therapeutic exercise are often prescribed. Physiatrists are expert in the prescription of prosthetic and orthotic devices, as well as electrical and mechanical assistive devices.

Physiatrists perform several different roles in several settings in todays health care system. Concerning inpatient rehab services, the PM&R specialist is the attending physician for patients who are admitted to rehabilitation hospitals or units. The PM&R specialist is frequently the manager of care and the primary care physician for severely disabled patients. In addition, consultations are a major part of the practice both on an inpatient and outpatient basis. A recent survey of Academy members showed that the most prevelant services rendered were inpatient rehabilitation management, electrodiagnosis, consultations and prosthetics and orthotics prescriptions and training.

The patients seen range across all ages but there is a heavy geriatric component. Our manpower survey specifically indicated that about 39% of patients seen were over 65, 33% between 40 and 65, 21% 21 to 39, 9% 14 - 20 and 10% under 14. In addition, the manpower survey indicates that stroke, arthritis are two of the four most prevalent types of conditions seen and those conditions are common to the aged. General demographic data reflect an increase in elderly with the U.S. from 12% now to about 22% by the turn of the century. The most frequently seen conditions seen are pain, stroke, general neurologic conditions, arthritis, spinal injury, amputation.

The GMENAC estimated a need for 4,060 physiatrists by 1990. We believe the estimate was low because of a failure to recognize the increasing prevalence of conditions treated by physiatrists and the increasing use of their services. Since the report of GMENAC Medicare PPS and similar hospital cost containment measures have stimulated the utilization of rehabilitation services and other post acute care services. In addition, the numbers of aged and disabled are increasing.

The supply of physiatrists is still far short of even the GMENAC estimates. We estimate a supply of only about 2,500 board certified physiatrists in 1990. We will graduate about 600 - 800 residents between now and 1990 and our estimated annual attrition rate is about 40.

Recommendations: Provide financial incentives for the training of physical medicine and rehabilitation residents through Medicare and expansion of grant support for residency training.

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NEUROSURGICAL MANPOWER

A Comment on Certain Issues of Interest

to the

Council on Graduate Medical Education

submitted on behalf of the

American Association of Neurological Surgeons
and the
Congress of Neurological Surgeons

November 19, 1987

Baltimore, Maryland

NEUROSURGICAL MANPOWER

Neurosurgery has been debating issues of manpower since its birth as a modern specialty, with its American founder, Harvey Cushing, stating in the early 1900's that a ratio of one neurosurgeon/1,000,000 population was suitable for this country. During Cushing's time the neurosurgeon primarily treated patients with brain tumors and epilepsy. Since his time the scope of neurosurgery has expanded greatly as has the number of neurosurgeons. It is currently estimated the United States ratio is one neurosurgeon/70,000 population compared with 1/500,000 in Britain and 1/140,000 in Canada. These comparisons have led some non-neurosurgeon physicians and laymen to proclaim there are too many United States neurosurgeons. These proclamations rarely consider the differences between the United States and other countries with regard to geography, structure of the health care delivery system, and the peculiar demands of the population.

Manpower Studies

In order to study some of these differences neurosurgery has participated in a number of state, regional, and national studies of manpower in the past two decades. The first major detailed study was undertaken by the American Association of Neurological Surgeons (AANS) through a contractual arrangement with the National Institutes of Neurological Disease and Stroke in 1973. The resulting AANS Neurosurgical Manpower Study was published in 1975. This report dealt with practicing neurosurgeons, program directors, neurosurgeons in training, and manpower and workload in neurosurgery. Performed primarily by questionnaire the study was important in that it, for the first time, defined the scope of neurosurgery as currently practiced, the contents of neurosurgical training, something of the problems faced by program directors, and estimated the total neurosurgical population by 1985 to be approximately 3,950.

Neurosurgery participated in the Study on Surgical Services for the United States (SOSSUS) jointly sponsored by the American College of Surgeons and the American Surgical Association. Finding a reduced number of skilled neurosurgical procedures being done per neurosurgeon it advised careful consideration of the potential benefits to be gained by regionalization of care.

The next major study of neurosurgery was that of Mendenhall and co-workers who, with support from the Robert Woods Johnson Foundation, exhaustively studied the major medical and surgical specialties in the country. Mendenhall used as his primary tool a week long professional diary which in the case of neurosurgery was completed by 426 neurosurgeons (a 63% response rate) chosen at random from the AMA master data files. This study established nationally and by US census regions several important facts about the practice of neurosurgery in the United States with more accuracy than had previously been obtained. For example, the mean number of professional hours per week of a neurosurgeon varied from 63.3 in the New England area to 50.6 in the mountain area of the western region. The weekly daily patient encounters varied from 161.0 in the east south central area of the southern region to 69.8 in the pacific area of the western region. Similar marked regional differences were noted throughout the report. The study, completed in 1981, suggested any policy which governs future manpower numbers in neurosurgery must be based upon close scrutiny of these regional differences -- their extent and explanations.

Future neurosurgical needs were studied by the Graduate Medical Education National Advisory Committee of the Department of Health and Human Services using a needs based model. This study is important because for the first time an attempt was made to calculate the number of neurosurgeons needed on the base of an estimate of incidence and prevalence of disease treated by a neurosurgeon. It established a basic need of 2,793 neurosurgeons by 1990 with a range of 2500 to 2800 and predicted an excess of close to 1,000 neurosurgeons. The study has been criticized extensively for several reasons, however. The Delphi Panel that was put together to review neurosurgery, and other specialties was formed hastily and was given little time to review incidence and prevalence data. In addition, the final numbers calculated were developed by an "objective" panel whose primary function was to adjudicate differences between specialties where scope of practice overlapped. No final data is available on the accuracy of the process.

Continuing this commitment to investigate and learn, the leadership of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons is currently putting together an extensive manpower survey of the specialty. The results are not available at the time of this report.

Supply

Based upon an extensive review of available data some of which admittedly is several years old, it is estimated there are 3,500 individual physicians in the United States whose practice is limited, largely, if not entirely, to surgical treatment of diseases of the nervous system. Since no suitable definition of a proper density of neurosurgeons has ever been developed it is impossible to say whether these data indicate enough neurosurgeons. One can, however, make some statements regarding the impact current production of neurosurgeons has had upon the distribution of neurosurgeons, and draw some conclusions on the availability of neurosurgical care. Since 1960 the percentage of communities 50,000 to 200,000 in population with Board certified neurosurgeons has increased from 40% to better than 75%. For towns of 30,000 to 50,000 that percentage has risen from 8% to 27%. In 1982 it was determined based upon current systems of emergency medical service and communication that less than 2% of the U.S. population did not have access for timely emergency neurosurgical services exemplified by the patient with a head injury and an acute epidural hematoma.

Future Needs

It is impossible at this time to make accurate forecasts about future needs of neurosurgeons, simply because it is impossible to make predictions about future needs for neurosurgical care.

At the time of the studies mentioned above, from the initial AANS study to that of GMENAC, there were no predictions regarding the value of such technology as magnetic resonance imaging, brain tissue transplant procedures, and the use of neurosurgical skills to affect the manipulation of brain genetic abnormalities. The effects of present governmental policy related to cost containment and the education of foreign medical graduates were not apparent. In retrospect there were not formulae available which would permit one to accurately access the impact of these variables on prediction.

It is argued by some that two major factors which will influence the future need for neurosurgeons, are public demand for services and government policies.

If there is one consistently accepted position in the debate over neurosurgical manpower, it is that a federal policy of two decades ago was ill conceived in doubling the number of medical school graduates.

If one accepts the assumption that with some variation in distribution the number of neurosurgeons today is such that there is adequate access to care then one does not have to be concerned with future numbers. One must concentrate, instead, upon net demand, a balance between services requested, and those for which the public are willing to pay. This is primarily an economic issue, which can be studied by looking at the practice of the public in requesting neurosurgical. The AANS Manpower Study, which is currently being developed will, among other analyses, look at the economic nature of the practice of most neurosurgeons in this country, including the developing practice, the established practice, and the practice in the throes of termination.

Financing

Postgraduate medical education programs in neurosurgery are primarily university based and are largely financed through hospital-patient income. Besides the delivery of patient care, other major activities of the resident physician include basic and clinical research, and teaching. Financing of these activities is through private and public sources.

It would be unrealistic to accept the proviso that the public does not have an interest in the financing of graduate medical education. On the negative side public support of residency training programs do increase the short-term direct costs of medical care. On the positive side, investment by the public in resident graduate medical education can be equated with essential research and development programs so necessary to insure a future supply of quality medical care. Young professionals of all walks of life, whether lawyer, young executive, or military officer are paid for service rendered while preparing for greater responsibilities. We must accept this with the young physician. The major question is, who should provide the funds? The funding must be through third party payors, hospitals, and governments.

Conclusions

1. The proper density and distribution of neurosurgeons in this country will not be determined by a study, but by an ongoing analysis balancing realistic appraisals of technological advances with public demand.
2. The debate on financing graduate medical education should focus more on the value to beneficiaries of resident services, and less on some arbitrarily defined scheme of price support.
3. Federal policy should support conclusions 1 and 2.

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STATEMENT

of

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Submitted to the

COUNCIL ON GRADUATE MEDICAL EDUCATION

November 5, 1987

The American College of Obstetricians and Gynecologists (ACOG) is pleased to have this opportunity to comment on issues under consideration by the Council on Graduate Medical Education. In particular, the College would like to highlight the effect of the increased cost of liability insurance on obstetric manpower.

ACOG is an organization comprised of more than 26,000 physicians specializing in women's health care, including over 90 percent of all board-certified obstetrician-gynecologists. The purpose of the College is to establish and maintain the highest possible standards of education, practice, and research in obstetrics and gynecology.

We strongly agree with the Council's Subcommittee on Physician Manpower which concluded in its draft report that it is impossible to quantify the aggregate supply of and (especially) the demand for physicians. The Graduate Medical Education National Advisory Committee (GMENAC) predicted that in 1990 there would be a total of 38,500 physicians listing themselves as obstetrician-gynecologists. The actual figure will be about 36,000. GMENAC calculated there would be 6,200 obstetric and gynecologic residents in 1990; there are now 4,600 and numbers are declining by 1-2 percent per year. GMENAC projected that 37 percent of all deliveries would be done by family physicians in 1990; the numbers are now about 15 percent and declining. GMENAC projected a surplus of 10,500 obstetrician-gynecologists by 1990; we are now in the midst of a distinct shortage in many areas.

As noted by the Subcommittee, many variables affect supply and demand projections. Of particular concern to us is the fact that liability pressures are resulting in large numbers of physicians quitting the practice of obstetrics. As of 1985, 12.3 percent of obstetricians nationally had given up obstetrics due to liability pressures. These physicians stopped their obstetric practices at younger ages than would otherwise be expected: 22.5 percent between ages 35 and 44, 28.9 percent between ages 45 and 54, and 30.7 percent between ages 55 and 64. Data for 1987, now being gathered, are expected to show an even larger percentage of obstetrician-gynecologists giving up obstetrics.

Large numbers of family physicians are also being forced to discontinue obstetrics as a result of the high cost of liability insurance to cover an obstetric practice. One-third of California's family physicians, almost 40 percent of Texas family physicians, and approximately one-half of Nevada's rural family physicians have stopped practicing obstetrics. Three hundred of 441 family physicians or 68 percent of those responding to a recent Alabama survey have stopped delivering babies.

These trends exacerbate the problem of access to maternity care, particularly in rural and underserved areas. For example, 67 Georgia counties and 28 Alabama counties are without a provider of obstetric care. If the trends continue unabated, obstetric care will become scarce even in the face of a projected surplus of physicians.

Other variables will affect demand for the services of obstetrician-gynecologists to an extent not yet known. Heterosexual and perinatal transmission of AIDS are rapidly growing and are a most serious problem. Demand for infertility care has almost doubled since 1980, both because of increased fertility problems due to sexually transmitted disease and delayed childbearing, and because of new technology to relieve infertility. No one can predict today the effect that developments such as immunization against papillomavirus, socio-cultural changes which lead to increased or decreased family size, new family planning technologies, or hormonal analogs to eliminate endometriosis will have on the demand for obstetric and gynecologic services.

Given our inability to fully anticipate these events or their impact on the supply of or demand for obstetrician-gynecologists, policies which would have a dramatic effect on physician supply must be approached with extreme caution. We concur with the Subcommittee on Physician Manpower that "there is no convincing evidence to suggest that the projected oversupply of physicians will necessarily lead to socially undesirable consequences."

We recommend that the Subcommittee on Physician Manpower include obstetrics and gynecology in the context of its discussion of primary care. Obstetrics and gynecology has been recognized as a primary care specialty in formal statements by the American Medical Association (AMA), Association of American Medical Colleges (AAMC), Council of Medical Specialty Societies (CMSS), and American College of Surgeons (ACS). This designation is borne out by data from the USC-Mendenhall study, for example, which reported that 78 percent of all encounters between obstetrician-gynecologists and patients could be defined as primary care, and National Center for Health Statistics data reporting that 62 percent of all ambulatory visits to obstetrician-gynecologists were for "non-illness" care. Assuming there is no significant change in the liability risk experienced by obstetrician-gynecologists, and considering that population cohorts show an increase in the female population aged 35 and older, the character of obstetrician-gynecologists' practice may change to emphasize even further well woman/primary care.

With respect to the Commission's goal of increased representation of minorities in the health professions, the College would like to note that obstetrics/gynecology is a popular specialty with black physicians, second only to internal medicine. According to AMA data, consistently over 12 percent of all black residents are in obstetric and gynecologic programs, compared to 6.4 percent of residents overall.

Women have also entered the specialty in large numbers. Fifty percent of all obstetric and gynecologic residents are now women; nearly 20 percent of all obstetrician-gynecologists are women, with the numbers on the increase.

ACOG strongly supports the conclusion in the draft report of the Subcommittee on Graduate Medical Education (GME) Programs and Financing that, "Changes to the way GME is financed should be undertaken in an evolutionary manner, rather than precipitously. To do otherwise would run substantial risk of unanticipated adverse results." Over the long run, the reimbursement principles of the College favor alternative support mechanisms rather than reliance on direct patient care dollars for the educational development and research components of GME.

The College is also on record in support of a loan repayment program with a period of obligated service, as recommended by the Subcommittee on Physician Manpower. We believe the loan repayment option could serve as a valuable recruiting tool for medically underserved communities.

In conclusion, the College appreciates the fact that the Commission is grappling with very difficult issues. However, it is appropriate to recall the words of a small town Minnesota philosopher, Garrison Keillor who, at the very least, the Chairman, Dr. Neal Vanselow will recall said, "Some luck lies in not getting what you thought you wanted, but in getting what you have, which once you have it you may be smart enough to see is what you would have wanted, had you known.'"

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AMERICAN SOCIETY OF CLINICAL ONCOLOGY ASCO

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October 26, 1987

Mr. Paul Schwab
Executive Secretary
Council on Graduate Medical Education
Health Resources and Services Administration
5600 Fishers Lane, Room 14-05
Rockville, MD 20857

Dear Mr. Schwab:

I appreciated the opportunity to discuss the forthcoming meeting of the Council of Continuing Medical Education. Since the meeting will concentrate on the problems of primary care physicians, the American Society of Clinical Oncology will not send a representative.

However, the Society is interested in your program, data, and conclusions. We would appreciate receiving appropriate publications resulting from the meeting.

I am enclosing 18 copies of reprints relative to Medical Oncology in which we have addressed the problem of manpower supply in this subspeciality. Medical Oncology has pioneered concepts of the contents of its specialty, training programs, guidelines for training programs, certification of subspecialties, and assessment of manpower needs. I hope the members of the Council would find the enclosed reprints of value.

Sincerely yours,

BJKennedy

B. J. Kennedy, M.D.
President, ASCO

BJK:mh
Enclosure

In Fundamentals of Cancer Chemotherapy
Edited by S.K.Carter and K. Hellman,
McGraw-Hill Book Company, New York, pp. 416-421, 1966.

Chapter 43

Evolution of Medical Oncology as a Subspecialty

B. J. Kennedy

Medical oncologists are physicians who have been broadly trained in internal medicine and have subspecialty expertise in neoplastic diseases. With their special skills and refined clinical judgment in matters relating to neoplastic diseases, they are equipped to provide a comprehensive assessment of the problems encountered in cancer and to coordinate the professional disciplines and modalities of treatment necessary for patient management. The oncologist plays a unique role as the focal physician in the established requirement for integrated multidisciplinary approaches to cancer therapy beyond the confines of chemotherapy alone.

In the United States, medical oncology was recognized as a subspecialty of internal medicine in 1972. With a sound foundation in internal medicine and a firm grounding in the principles of neoplastic diseases, the medical oncologist, serving primarily as a consultant, integrates a team of health professionals that employs many scientific and clinical skills in order to prevent, detect, control, and cure cancer. These trained physicians are advocates of the cancer patient. A major educational effort was undertaken to train medical oncologists to meet the national need and demand.[1-5] An international need for medical oncologists was also noted.[6]

DEVELOPMENT OF MEDICAL ONCOLOGY

Recognizing the significant developments in the study of neoplasms and the treatment of patients afflicted with cancer, the American College of Physicians in 1957 established a Committee on Cancer to encourage participation by internists in the care of patients with neoplastic diseases. Through a gradual evolution, the subject of cancer was increasingly stressed in the field of internal medicine.

More than 10 years later, in 1969, the American Society of Clinical Oncology established a committee to develop the role of the internist in cancer. The concept of the medical oncologist ensued. Numerous medical educators emphasized the importance of the emerging role of the internist in cancer and the new field of medical oncology. The decision of the American Board of Internal Medicine in February 1971 to offer certification in the subspecialty of medical oncology was approved by the American Board of Medical Specialties in February 1972.[7]

A Subspecialty Committee on Medical Oncology of the American Board of Internal Medicine established requirements for certification in medical oncology and prepared a certifying examination. In an initial report in 1973, the committee defined subjects of direct relevance to clinical medical oncology and established goals for training in this field.[8]

SCOPE OF MEDICAL ONCOLOGY

The scope of the subject matter in training for medical oncology encompasses the broad field of cancer, including the following areas:

1. Etiology
2. Prevention
3. Epidemiology
4. Tumor biology
5. Detection and diagnosis
6. Patient management
7. Host effects
8. Investigational orientation
9. Gerontology

It is intended that oncologists be cognizant of the contents of these subjects, since their practice involves all these matters. A broad spectrum of neoplastic diseases within the scope of medical oncology includes the following:

1. Bone
2. Breast
3. Endocrine system
4. Gastrointestinal
5. Genitourinary
6. Gynecologic
7. Head and neck
8. Hematologic
9. Nervous system
10. Pulmonary
11. Skin
12. Soft tissue

Some physicians in major centers concentrate their efforts on specific areas. However, practicing medical oncologists cover the broader field of neoplasms.

GUIDELINES FOR TRAINING PROGRAMS

Once the scope of medical oncology was defined, its role was emphasized further. With the development of new training programs for medical oncology in departments of medicine, the Subspecialty Committee for Medical Oncology of the American Board of Internal Medicine defined essential guidelines.[5] A trainee in medical oncology must have completed 3 years of training in general internal medicine. Highlights of the subspecialty guidelines follow.

> The training program in Medical Oncology must provide advanced training that will make it possible for the physician to acquire the expertise to practice as a consultant in Medical Oncology. The program should not only provide training in the techniques required and fundamental clinical skills necessary for the practice of Medical Oncology, but should also provide an emphasis on scholarship, continuing self-instruction, development of critical judgement, and the ability to make appropriate decisions.[5]

Since a trainee in medical oncology must learn to integrate many scientific skills in order to prevent, detect, and manage neoplastic diseases, the environment of the training program should provide a working knowledge of the following allied health areas:

1. Diagnostic radiology and nuclear medicine
2. Gynecologic oncology
3. Pathology
4. Pediatric oncology
5. Psychosocial issues
6. Radiation oncology
7. Rehabilitation
8. Surgery

It was stressed that medical oncologists must be competent internists.

> The trainees should develop skill in functioning as primary care physicians. They should be able to establish a relationship with the individual or family and provide continuing surveillance of health needs, comprehensive care for the acute and chronic disorders for which they are qualified, and access to the health delivery system for disorders requiring the services of other specialists.[9]

It was essential that training programs have an investigational component. According to the guidelines, the trainee "should learn the *design* and interpretation of research studies, *evaluation* of investigative methods, and *interpretation* of data and develop competence in critical assessment of new therapies and the medical literature."[9]

In June 1978, a workshop on graduate education in medical oncology was sponsored by the National Cancer Institute.[10] A need for more definitive guidelines for graduate education in medical oncology was emphasized. The Residency Review Committee then determined guidelines for training in all the subspecialties of internal medicine in order to provide a basis for the accreditation of individual training programs that was begun in 1982 and expected to be completed by 1985. The evolution of medical oncology played a significant role in stimulating the preparation of these guidelines for training in all subspecialties of internal medicine and the concept of the need for accreditation of individual training programs.

PROVIDER NEEDS IN MEDICAL ONCOLOGY

In undertaking the process of training and certifying internists as medical oncologists, attempts have been made to estimate the total number of medical oncologists needed in the United States.

In 1966, a need for additional oncologists in the United States and Canada was recognized.[11] Bergsagel attempted to determine the status and future requirements in terms of personnel for medical oncologists in the province of Ontario, Canada (D. Bergsagel, personal communication, 1975). Of a projected 1813 new cancer cases per year in a population of 500,000, the medical oncology case load was 845 patients. It was estimated that in an academic center, a medical oncologist would consult on 100 new patients a year and do follow-up care on 60 to 80 patients in addition to academic duties. In a nonacademic center, it was estimated that a busy, experienced, well-organized medical oncologist should be able to see 150 new oncology patients a year and do follow-up care on 100 to 200 patients.

Substantiation of these estimates was provided by Mosher and associates,[12] who analyzed the workload of three medical oncologists in private practice in California. Of the patients managed by that group, 61 percent were cancer patients. Each member of this group consulted on 87 new oncology patients a year and was involved in the follow-up management of 51 new oncology patients. At least 50 percent of these patients could be expected to be treated by the group for 2 years or more.

Effective subspecialists do not spend 100 percent of their time in the practice of medical oncology. Based on the comparative effectiveness of other subspecialties and the experience of current practicing medical oncologists, it is reasonable to conclude that 60 to 70 percent of the oncologist's time will be spent on oncology, with the remainder accounted for by general internal medicine. A 60-h work week would seem realistic.

An assessment of personnel needs in selected clinical oncology specialties[13] projected the estimated supply and requirements for medical oncologists as follows:

	1977	1980	1985
Estimated supply	1130	1846	3165
"Best estimate" requirements	3305	3443	3665
Requirement based on 60-h work week, doing oncology 60 percent of the time	—	4303	4582

A survey of 75 institutions with medical oncology training programs was carried out in 1976. These institutions provided a total of 60,713 hospital beds, of which 26 percent were internal medicine beds. Seventeen percent of these internal medical beds were for medical oncology. In a single year, 304,950 clinic visits occurred. The survey of these 75 institutions revealed that 304 medical oncologists were currently in training and that 1256 had completed training programs.

Based on the number of trainees and the number who had applied to take the certifying examinations in medical oncology, it was projected that every other year over 500 candidates would be eligible for certification, of whom approximately 75 percent would be certified. Assuming a low rate of attrition, a goal of 2000 medical oncologists would be attained by 1981. In actuality, after five certifying examinations by the American Board of Internal Medicine held in 1973, 1975, 1977, 1979, and 1981, 2434 internists were certified as medical oncologists. After the next series of certifying examinations, medical oncology will probably rank second in numbers certified among the subspecialties of internal medicine. By 1985 the projected need of 3665 medical oncologists was met.

The Federated Council for Internal Medicine sponsored a National Study of Internal Medicine Manpower. Unfortunately, the 1981 report combined data on oncology and data on hematology and submitted data on an unidentified group under the heading of "Neoplastic Diseases." A projected deficiency in personnel was anticipated for 1990. The American Society of Clinical Oncology considered the report in the area of medical oncology to be inadequate and the conclusions to be inaccurate. At the current rate of training, there should be no deficiency of oncologists in 1990.

During the evolution of medical oncology, some hematologists expanded their interest in patient care to tumor systems other than those of the hematologic system. A few hematologists have proposed merging the two subspecialties. This would be unfortunate. The scope of knowledge for each subspecialty has expanded enormously. It is not feasible for clinicians to provide adequate care to patients by combining these two areas of medicine. In medical oncology, it is already recognized that training should be expanded to 3 years so that specialists will be able to provide qualified consultative care. Moreover, since the needs of the community are being rapidly met with respect to the required number in each of these subspecialties, the numbers in training might be reduced, and the available training funds might be utilized to emphasize the training of the clinical investigators who are needed.

The conflict between oncology and hematology is unique. No such problem exists in relation between the subspecialties of oncology-pulmonary, oncology-gastroenterology, oncology-endocrinology, and oncology-infectious disease, where there is a similar overlapping of clinical interests. The best progress will ensue if the fields of hematology and oncology are maintained as separate specialties, with training for at least 2 years required in each specialty. The practice of medical oncology should be performed by individuals with a commitment to cancer, not by individuals with a primary interest in another field.

A continuing awareness of the need for medical oncologists is being maintained so that a reasonable number of skilled subspecialists will not be exceeded. As the goal in terms of numbers of clinical medical oncologists needed is estimated, the distribution must also be considered. This requires a recognition of the need in communities in order to facilitate the placement of medical oncologists.

Medical oncology evolved rapidly in the United States. This specialty is now being recognized in other countries, but more slowly. In the United Kingdom a series of reports has demonstrated an increasing recognition of the important role played by the medical oncologist in clinical medicine.[34] Similar progress is occurring elsewhere.

IMPACT OF MEDICAL ONCOLOGY

The explosion in the number of trained medical oncologists has helped bring the necessary expertise into the community so that modern and competent care of patients with cancer is now available outside research and university centers. The availability of this care system has coincided with improved survival rates and cure rates for several types of cancer. There can be little doubt that the new oncologists are bringing the fledgling science to the people.

Although initially trained to apply the products of research in chemotherapy to the care of patients with advanced stages of cancer, the medical oncologist is developing research on disease biology aimed at developing more effective treatments. The medical oncologist has become a symbol of the cancer specialist, expected to provide judgment in the total management of the patient with cancer.

The increasing number of medical oncologists in the community has led to concern that clinical research at major research institutions will be altered. This is already the case. With qualified physicians in the community, the patient with cancer can remain closer to home, and the cost is lower. One can be proud of improving the quality of community cancer care. Some regard these educational efforts as a self-destructive process on the part of major medical cancer centers responsible for training and research. Certainly the methods of training and research will be altered. Research will be directed toward cancers that still defy cure or even control. These uncured diseases constitute the research problems that the major centers will face.

In order to prepare appropriately for the future and to advance the field of clinical research, investigation should be included as an integral and required part of this training.[15] The medical oncologist in practice should continue to play an integral part in clinical investigation. The field of medical oncology does not remain static. No one can predict the impact on personnel needs that would result if a significant discovery occurred in a major cancer in which the new treatment process would require additional physicians in order to attain control or cure. Hence, the basis for sound training programs that are flexible must be maintained.

CONCLUSION

Medical oncology has evolved as a subspecialty of internal medicine during the past 14 years in the United States. It has had a significant impact on cancer research, cancer education, and patient care in oncology. Medical oncologists must assume a major responsibility for the care of patients with cancer throughout the course of illness. They must orchestrate the other clinical disciplines in order to develop an appropriate treatment strategy for each patient. Finally, they must exploit their special competence in drug therapy in order to coordinate their skills with those of the surgeon, the radiotherapist, and the family physician.

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Medical Oncology Manpower Training: A Position Statement of the American Society of Clinical Oncology

MEDICAL ONCOLOGY has evolved to be one of the larger subspecialties of Internal Medicine in the United States. After the recognition of this subspecialty by the American Board of Medical Specialties, the scope of subjects with direct relevance to clinical Medical Oncology was defined, and guidelines for the minimal essentials for training were developed.[1] As with all subspecialties of Internal Medicine, the process is underway for accreditation of Medical Oncology training programs by the Residency Review Committee, which will assure the quality of training in Oncology. We can be proud of the accomplishments of medical oncologists in improving the quality of community cancer care, and the progress made in cancer research and education.

Medical Oncology is unique among the Internal Medicine specialties. The practicing oncologists do less general internal medicine than most subspecialists because the complexities intrinsic to skill maintenance require a full-time commitment to oncology. In a little over a decade, there has been an explosion in the number of medical oncologists that has had a significant impact on cancer education, cancer research, and the care of patients with cancer. Concern has been expressed regarding the potential overproduction of trained oncologists, a problem similar to that of the medical profession as a whole. In a national study of internal medicine manpower, it was concluded that "the directors of the teaching hospitals and the subspecialty fellowship programs show no inclination to reduce the number of subspecialists in training."[2]

To address the problem of total manpower, a survey of Medical Oncology training programs was made. The review covered 151 operational training programs in Medical Oncology. In these programs there are currently 767 trainees who will have completed at least two years of training by 1987. The current trainees will be eligible for the certifying examinations to be given in 1985 and 1987; there will be approximately 315 new trainees beginning in July 1985 who will be eligible for the 1987 examination. For the November 1985 examination, approximately 750 applications have been received, similar to prior years.

After the 1983 certifying examination, there are 2,975 oncologists certified by the American Board of Internal Medicine. This is close to the production estimates previously made, and by 1987 the number of oncologists should meet the calculated requirements. It would appear that by 1990 there will not be a deficiency of oncologists. The exact number of additional noncertified oncologists practicing medical oncology is unknown.

Training in Medical Oncology should be of high quality, providing clinical investigation and career training for academic oncologists. In order to assure the quality goals of oncology, and in an attempt to meet an adequate supply of medical oncologists, the following guidelines are recommended.

- New training programs should be restricted to institutions with a demonstrated commitment to clinical and/or basic research. Purely clinical programs without a modern research component should be discouraged. To assure the quality of education, training should occur in institutions where the faculty writes papers, participates in research, and has research grants.
- Discontinue programs currently without fellows. (There are seven such programs, four devoted to clinical training only).
- Delete programs offering clinical training with only patient care delivery, but continue those offering clinical research. The academic model for the acquisition and pursuit of new knowledge requires a clinical investigative attitude. (Eighteen programs with only clinical experience have 25 fellows. One with three fellows is phasing out, and four programs have no fellows.) Patient care by the trainee should be a learning experience. The trainee should not be utilized to service patient load.

From the Subcommittee of the Committee on Accreditation of Medical Oncology Training Programs.

This statement has been endorsed by the Board of Directors of the American Society of Clinical Oncology and Association of Directors of Medical Oncology Training Programs.

Address reprint requests to B.J. Kennedy, MD, Box 286, University Hospitals, Minneapolis, MN 55455.

Seminars in Oncology, Vol 12, No 4 (December), 1985: p xxv-xxvi

- Delete programs where more than four subspecialties of Internal Medicine and radiation therapy, surgery, and pathology are not represented in the institution. The trainees require exchange of experiences with the other specialities.
- To reduce US manpower excess, good foreign trainees should be attracted to US training programs but with a commitment to return to their homeland and to extend the benefits provided by Medical Oncology.
- Require the rotation of Internal Medicine residents to Oncology services to improve their training in medicine.
- Require more rigid definition of training programs in the combined Oncology-Hematology programs. There should be a clear definition of the separate training tracks and assurance of the quality of that training. Encourage combined programs to share experiences and facilities, but to maintain clear definition of the needs of each training track. The greatest proportionate increase (25%) in the number of entering fellows in all the subspecialties between 1982 and 1983 was in these combined programs.[2]
- Focus on funding for academic programs. Training grants for fellows intent on research careers should be encouraged. There is a critical need to increase the academic oncology base to help translate exciting developments of basic research into clinical application.
- In order to meet the academic and research needs of Medical Oncology and provide mature oncologic physicians, three-year training programs are needed.
- Seek methods to encourage or force a reduction of the number of trainees in Oncology by directors of the programs, including the large programs. Obtain commitments from program directors for reduction of the number of trainees (eg, up to 50% over five years).

SUMMARY

The evolution of Medical Oncology is facing its first major crisis, that of oversupply of trained oncologists. The tabulated number of certified medical oncologists does not constitute all of the physicians practicing Medical Oncology in the United States. Because of the adequate supply of medical oncologists in clinical practice, but a deficiency of academic oncologists dedicated to research careers, a reduction in training programs should emphasize those programs that lack research opportunities. These recommendations are in keeping with the report of the Long-Range Planning Committee of the American Society of Clinical Oncology of March 21, 1984. Plans to expedite these goals are being established.

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B.J. Kennedy, MD
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Bayard Clarkson, MD
Eugene Frenkel, MD
The Subcommittee of the Committee on Accreditation of Medical Oncology Training Programs

Medical Oncology Manpower Training: A Position Statement of the American Society of Clinical Oncology

By B.J. Kennedy, Paul Calabresi, Bayard Clarkson, and Eugene Frenkel

MEDICAL ONCOLOGY has evolved to be one of the larger subspecialties of Internal Medicine in the United States. After the recognition of this subspecialty by the American Board of Medical Specialties, the scope of subjects with direct relevance to clinical Medical Oncology was defined, and guidelines for the minimal essentials for training were developed.[1] As with all subspecialties of Internal Medicine, the process is underway for accreditation of Medical Oncology training programs by the Residency Review Committee, which will assure the quality of training in Oncology. We can be proud of the accomplishments of medical oncologists in improving the quality of community cancer care, and the progress made in cancer research and education.

Medical Oncology is unique among the Internal Medicine specialties. The practicing oncologists do less general internal medicine than most subspecialists because the complexities intrinsic to skill maintenance require a full-time commitment to oncology. In a little over a decade, there has been an explosion in the number of medical oncologists that has had a significant impact on cancer education, cancer research, and the care of patients with cancer. Concern has been expressed regarding the potential overproduction of trained oncologists, a problem similar to that of the medical profession as a whole. In a national study of internal medicine manpower, it was concluded that "the directors of the teaching hospitals and the subspecialty fellowship programs show no inclination to reduce the number of subspecialists in training."[2]

To address the problem of total manpower, a survey of Medical Oncology training programs was made. The review covered 151 operational training programs in Medical Oncology. In these programs there are currently 767 trainees who will have completed at least 2 years of training by 1987. The current trainees will be eligible for the certifying examinations to be given in 1985 and 1987; there will be approximately 315 new trainees beginning in July 1985 who will be eligible for the 1987 examination. For the November 1985 examination, approximately 750 applications have been received, similar to prior years.

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Training in Medical Oncology should be of high quality, providing clinical investigation and career training for academic oncologists. In order to assure the quality goals of oncology, and in an attempt to meet an adequate supply of medical oncologists, the following guidelines are recommended:

- New training programs should be restricted to institutions with a demonstrated commitment to clinical and/or basic research. Purely clinical programs without a modern research component should be discouraged. To assure the quality of education, training should occur in institutions where the faculty write papers, participate in research, and have research grants.
- Discontinue programs currently without fellows. (There are seven such programs, four devoted to clinical training only).

From the Subcommittee of the Committee on Accreditation of Medical Oncology Training Programs, the American Society of Clinical Oncology

Submitted Sept 30, 1985; accepted Oct 3, 1985

This statement has been endorsed by the Board of Directors of the American Society of Clinical Oncology and Association of Directors of Medical Oncology Training Programs

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- Delete programs offering clinical training with only patient care delivery, but continue those offering clinical research. The academic model for the acquisition and pursuit of new knowledge requires a clinical investigative attitude. (Eighteen programs with only clinical experience have 25 fellows. One with three fellows is phasing out, and four programs have no fellows). Patient care by the trainee should be a learning experience. The trainee should not be used to service patient load.
- Delete programs where more than four subspecialties of Internal Medicine and radiation therapy, surgery, and pathology are not represented in the institution. The trainees require exchange of experiences with the other specialties.
- To reduce US manpower excess, good foreign trainees should be attracted to US training programs, but with a commitment to return to their homeland to extend the benefits provided by Medical Oncology.
- Require the rotation of Internal Medicine residents to Oncology services to improve their training in medicine.
- Require more rigid definition of training programs in the combined Oncology-Hematology programs. There should be a clear definition of the separate training tracks and assurance of the quality of that training. Encourage combined programs to share experiences and facilities, but to maintain clear definition of the needs of each training track. The greatest proportionate increase (25%) in the number of entering fellows in all the subspecialties between 1982 and 1983 was in these combined programs.[2]
- Focus on funding for academic programs. Training grants for fellows intent on research careers should be encouraged. There is a critical need to increase the academic oncology base to help translate exciting developments of basic research into clinical application.
- In order to meet the academic and research needs of Medical Oncology and provide mature oncologic physicians, 3-year training programs are needed.
- Seek methods to encourage or force a reduction of the number of trainees in Oncology by directors of the programs, including the large programs. Obtain commitments from program directors for reduction of the number of trainees. (eg, up to 50% over 5 years).

SUMMARY

The evolution of Medical Oncology is facing its first major crisis, that of oversupply of trained oncologists. The tabulated number of certified medical oncologists does not constitute all of the physicians practicing Medical Oncology in the United States. Because of the adequate supply of medical oncologists in clinical practice, but a deficiency of academic oncologists dedicated to research careers, a reduction in training programs should emphasize those programs that lack research opportunities. These recommendations are in keeping with the report of the Long-Range Planning Committee of the American Society of Clinical Oncology of March 21, 1984. Plans to expedite these goals are being established.

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1. Calabresi P, Carbone PP, Kennedy BJ, et al. The subspecialty of oncology. Semin Oncol 4 i–iv, 1977
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Training Programs in Medical Oncology

To the editor: The evolution of medical oncology has had a significant impact on cancer education, cancer research, and care of patients with cancer. Concern has been expressed regarding the potential overproduction of trained oncologists. Our survey has concluded that with 2975 oncologists already certified and with over 1000 trainees eligible for the 1985 and 1987 certifying examinations, by 1990 there will be no deficiency of oncologists. The American Society of Clinical Oncology has issued a position statement emphasizing that training in medical oncology should be of high quality, providing clinical investigation and career training for academic oncologists. To ensure the quality goals of oncology and to meet an adequate supply of medical oncologists, the following guidelines were recommended:

1. New training programs should be restricted to institutions with a demonstrated commitment to clinical or basic research, or both. Purely clinical programs without a modern research component should be discouraged.
2. Discontinue programs currently without fellows.
3. Delete programs offering clinical training with only patient care delivery, but continue those offering clinical research. The academic model for the acquisition and pursuit of new knowledge requires a clinical investigative attitude. The trainee should not be used to service the patient load.
4. Delete programs in which more than four subspecialties of internal medicine and radiation therapy, surgery, and pathology are not represented in the institution.
5. To reduce U.S. manpower excess, good foreign trainees should be attracted to U.S. training programs, but with a commitment to return to their homeland.
6. Require the rotation of internal medicine residents to oncology services to improve their training.
7. Require more rigid definition of training programs in the combined oncology-hematology programs. There should be a clear definition of the separate training tracks and assurance of the quality of that training.
8. Focus on funding for academic programs. Training grants for fellows intent on research careers should be encouraged. There is a critical need to increase the academic oncology base to help translate developments of basic research into clinical application.
9. In order to meet the academic and research needs, 3-year training programs are needed.
10. Seek methods to encourage or force a reduction of the number of trainees in oncology, including the large programs; and obtain commitments from program directors to do so.

Because of the adequate supply of medical oncologists in clinical practice, but the deficiency of academic oncologists dedicated to research careers, a reduction in training programs should focus on those programs that lack research opportunities.

B.J. Kennedy, M.D.
Paul Calabresi, M.D.
Bayard Clarkson, M.D.
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Committee on Accreditation of Medical Oncology Training Programs, American Society of Clinical Oncology; Chicago, IL 60611

Research in Divisions of General Internal Medicine

To the editor: A recent article by Friedman and Pozen (1) has reported on a survey of the chairmen of departments of medicine about the status of their general internal medicine divisions. I am disappointed in the shortsighted views of the chairmen that the academic viability of general internal medicine divisions and their faculty is dependent on research productivity.

The terms academic productivity, academic viability, and research capability are used interchangeably in the article. In the methods section, it was stated that the chairmen were asked questions in four areas: two were "factors affecting the academic productivity of the division and the field of general internal medicine as a whole" and "departmental plans for improving the division's academic productivity." However, in Table 4 (Factors Affecting Academic Viability of General Internal Medicine), academic viability was substituted for academic productivity. In Table 5 (Plans to Encourage Research Capability of General Internal Medicine Divisions), research capability was substituted for academic productivity. Because the survey questions were developed in cooperation with some of the chairmen, I assume that the equation that academic productivity equals academic viability equals research capability partially reflects the chairmen's bias.

The article reveals that the general internal medicine divisions have largely satisfied the original objectives for their development: that is, providing primary care and teaching. At this time, 83% of the chairmen expected their general internal medicine faculties to do research; three quarters intended to encour-

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* Gelber HE. The origin of the origin of species. *Review of Darwin and the Mysterious Mr. X: New Light on the Evolutionists* By Eiseley L. *The New York Times Book Review* 1979 July 22:16.

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Medical Oncology Manpower Supply

B.J. Kennedy, MD

An explosion in the number of trained medical oncologists has led to concern that an overproduction will occur. A survey of 154 medical oncology training programs revealed 767 current trainees—316 first year, 307 second year, and 144 third year. Seventeen programs contained 301 persons (38.5%). After the 1985 certifying examination, 3,659 oncologists were certified. With approximately 750 eligible candidates for each examination, and assuming a 75% pass rate, by 1989 there will be 4,779 certified medical oncologists. By 1990, there will be no deficiency of clinical medical oncologists, but there appears to be a lack of academic oncologists. In order to assure the quality goals of oncology, and in an attempt to meet an adequate supply of medical oncologists, a position statement has been published by the American Society of Clinical Oncology. To avoid an overproduction of medical oncologists, an ongoing assessment of the number needed is warranted.

Key words: education, over production, assessment, position.

INTRODUCTION

Medical oncology is a major subspecialty of internal medicine. Medical oncologists are physicians broadly trained in internal medicine who have special skills and refined clinical judgment in matters relating to neoplastic diseases. They are equipped to provide comprehensive assessment of the problems encountered in cancer and to coordinate the professional disciplines and modalities of treatment necessary for management of patients with cancer. As a result, medical oncology has had a significant impact on cancer education, cancer research, and the care of patients with cancer internationally. Concern has been expressed that there will be a surplus of medical oncologists in the near future, similar to the projected surplus of physicians in other specialities in the United States.

Recognizing significant developments in the study of neoplasms and the treatment of patients afflicted with cancer, the American College of Physicians established a committee on cancer in 1957 to encourage participation of the internist in the care of patients with cancer. In 1969, the American Society of Clinical Oncology established a committee that emphasized the importance of the emerging role of the internist in cancer and the new field of medical oncology. The decision of the American Board of Internal Medicine in February 1971 to offer certification in the subspecialty of medical oncology was approved by the American Board of Medical Specialties in February 1972.

The Subspecialty Committee on Medical Oncology of the American Board of Internal Medicine established requirements for certification in medical oncology and established goals for training in clinical medical oncology [1]. The scope of subjects with direct relevance to clinical medical oncology was defined. With a sound foundation in internal medicine and a firm base in the principles of neoplastic diseases, the medical oncologist, serving primarily as a consultant, was envisioned as an integrator of a team of health professionals that provides many scientific and clinical skills to prevent, detect, control, and cure cancer. Major educational efforts were undertaken to train medical oncologists to meet the national need and demand. An international need for medical oncologists was also apparent.

Once the scope of medical oncology was defined, and with the development of new training programs for medical oncology, the Subspecialty Committee defined essential guidelines for training [2]. These guidelines stressed that the training must make it possible for the physician to acquire the expertise to practice as a consultant in

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medical oncology, and that a working knowledge of other allied health areas be acquired. It was argued that trainees develop skills to function as primary care physicians. It was essential that training programs have an investigational component so that the trainee could learn the design and interpretation of research studies, evaluate and interpret data, and develop competence in critical assessment of new therapies. These guidelines became the basis for the current guidelines employed by the Residency Review Committee in the process of accrediting subspecialty training programs in medical oncology.

TABLE I. 1977 Estimate of Supply and Need of Medical Oncologists [5]*

	1977	1980	1985	1990
Estimated supply	1,130	1,846	3,165	—
"Best estimate" requirement	3,305	3,443	3,665	—
Requirement based on 60-hour week, doing 60% oncology	—	4,303	4,582	4,749

*1983, 2,977 certified

MANPOWER NEEDS IN MEDICAL ONCOLOGY

In undertaking the process of training and certifying internists as medical oncologist, attempts were made to estimate the total number of medical oncologists needed in the United States. Bergsagel [3] attempted to determine the manpower status and future requirements for medical oncologists in the Province of Ontario, Canada. With the projected 1,813 new cancer cases per year in a population of 500,000, the medical oncology caseload was 845 patients. It was estimated that in an academic center, a medical oncologist would consult on 100 new patients per year with follow-up care on 60–80 patients. In a nonacademic center, a busy, experienced, well-organized medical oncologist was estimated to be able to see 150 new oncology patients per year and do the follow-up care on 100–200 patients. Moser [4], in analyzing the workload of three medical oncologists, reported that 61% of their patients had cancer. Each member of this group consulted on 87 new oncology patients per year and was involved in the management of 51 new oncology patients.

In 1977, an assessment of manpower needs in selected clinical oncology specialties projected the estimated supply and requirements for medical oncologists [5] (Table I). In 1976, the author conducted a survey of 75 institutions claiming medical oncology training programs. This revealed that 304 medical oncologists were in training and 1,266 had completed training programs. Based on the number of trainees and the number who had applied to take the certifying examinations in medical oncology, it was projected that every other year over 500 candidates would be eligible for certification of whom approximately 75% would be certified. Assuming a small rate of attrition, a goal of 2,000 medical oncologists would be attained by 1981. In actuality, after seven certifying examinations by the American Board of Internal Medicine, 3,659 internists have been certified as medical oncologists through 1985. At that rate, the projected need of 3,665 medical oncologists by 1985 was met.

The Federated Council for Internal Medicine sponsored a National Study of Internal Medicine Manpower. A projected deficiency in oncology manpower was anticipated by 1990. Many persons regarded the report as inadequate and the conclusions incorrect. It was anticipated that at the current rate of training, there should be no deficiency of oncologists in 1990.

Concerned with the increasing production of medical oncologists, the potential overproduction, and the impact of a surplus, the American Society of Clinical Oncology established a subcommittee of the Committee on Accreditation of Medical Oncology Training Programs. A further survey of medical oncology training programs was conducted to reassess the production estimates previously made and to project again the number of medical oncologists available to meet the estimated requirements.

METHODS AND MATERIALS

During the fall of 1984, 154 medical oncology training programs were reviewed. A survey form was sent to each program director, and subsequently a second survey was sent to those programs claiming oncology-hematology combined programs. The total number was only 11 fewer than that reported in the National Study of Internal Medicine Manpower IX [6].

Of the 154 programs, 151 were operational. Three programs were not functional or had been discontinued. Two programs were in the process of being phased out but were included in the tabulation because trainees currently were still in the training program. The total number of programs offering a first-year training program in 1984 was 149.

Following completion of the survey, the data were reviewed and a position statement was prepared. This statement was endorsed by the Board of Directors of American Society of Clinical Oncology and the Association of Directors of Medical Oncology Training Programs [7,8].

RESULTS

Of the 151 operational programs, 49 were registered as medical oncology only. In these programs, there were

303 fellows, which was 40% of the total number of fellows. The combined oncology-hematology programs numbered 105. Of these, 27 offered separate training tracks, and 78 offered an optional choice of track. Three programs offered a specific oncology track plus an oncology-hematology tract.

The total number of all the current trainees for 1984–1985 was 796. A few of these were designated as being on a hematology track. The total number designated as medical oncology track trainees was 767, eliminating those known to be on a hematology track. The total number of available first-year positions was 374. Eliminating those who had chosen hematology training only, there were 316 first-year oncology trainees and 307 second-year oncology trainees (Table II). Although 374 first-year positions were listed as available, the number varies according to the total number of trainees. With an increase in second- or third-year trainees, the limitation of funding may temporarily decrease the number of first-year positions.

A third-year trainee program was offered by 132 programs. However, only 69 of those programs had third-year trainees (52%). The total number of third-year medical oncology trainees was 144. No third-year training was offered by 19 programs. Those 19 programs had only 35 trainees.

Size of Individual Programs

The number of trainees in various programs was recorded (Table III). Seven programs had no trainees; 19 had only one. The total number of programs having nine or fewer trainees was 134 (61.5%).

Seventeen programs had 10 or more trainees. These 17 programs contained 301 trainees (38.5%). Six of these programs had 21–42 trainees, totalling 146 trainees (18.6% of the total number of trainees).

1986 Projection

An attempt was made to determine the number of first-year positions planned for 1986. This was tabulated as 328. Plans to reduce the number of positions were stated in 15 programs, with a loss of 19 trainees. However, 11 programs were planned to increase their number of trainees, totalling 11. Four of these programs had only one or no current trainee. It is apparent that there was no major plan for reduction of trainees. A few programs, however, emphasized that reduction in the number of trainees had already taken place prior to the survey year.

Comments from Directors

In the survey, some directors provided supplementary information regarding the nature of their program, reasons for changing the number of trainees, and comments regarding the nature of combined oncology-hematology programs.

TABLE II. Trainees in Medical Oncology 1984-85

Training year	Total No.	Oncology
First[a]	327	316
Second	319	307
Third[b]	150	144
Total	796	767

[a] 374 positions available

[b] 132 programs offer.

TABLE III. Size of Oncology Training Programs

No. of trainees	No. of programs	No. of "oncology only" programs
0	7	4
1	19	5
2	22	5
3	28	7
4	17	7
5-9	41	11
10 +	17	10
Total	151	49

For those directors who previously had reduced the number of trainees, a voluntary reduction was carried out because of national policy, as advised by the American Society of Clinical Oncology because of perceived overproduction of medical oncologists or because of the oversupply of oncologists and superior programs in larger centers. Some centers reduced their program or were discontinuing it because of lack of funds or reduction in funds. One program that changed to an academic 3-year program reduced the number of first-year trainees and extended the duration of training. It altered the distribution in the number of trainees with the same funding.

With respect to planned increases in the number of trainees, the reasons included an increase in the clinical caseload of the institution, increased funding, or an increase in the number of academically oriented trainees.

Combined Oncology-Hematology Programs

In the follow-up survey, comments were made regarding the combined program. It was apparent that there are a wide variety of programs offered. The comments included such items as the following: "Ninety percent of the fellows take the Oncology Boards"; "all trainees take a two-year Oncology program and a third year if they want Hematology"; "from a practical point, no trainee wants a straight two-year Hematology track." One program did not train 2-year trainees for hematology only. Often it was the fellow's decision to decide which track they wished to pursue, but some programs did not encourage double certification. The nature of a few of these training programs appeared vague, and separate tracks were difficult to identify.

During the evolution of medical oncology, the hematologists have treated patients with leukemia, lymphoma, and myeloma. With their expertise, it is anticipated that some will continue to do so.

DISCUSSION

Medical oncology has evolved to be one of the larger subspecialties of internal medicine in the United States. In a little over a decade, there has been an explosion of the number of medical oncologists that has had a significant impact on cancer education, cancer research, and the care of patients with cancer. To assess whether the concern regarding the potential overproduction of trained oncologists is real, a manpower survey of medical oncology programs provided data that can be a guide to the future needs in the training of medical oncologists.

After the 1985 certifying examinations, there were 3,659 oncologists certified by the American Board of Internal Medicine. This is on target according to the estimates previously made. Approximately 750 candidates took the 1985 certifying examination, a number similar to the previous year. With the information of the current number of trainees, projections can be estimated through 1990. Two methods of calculations were employed to establish a projected number:

1. If there are 750 eligible candidates each year (based on approximately the same number the past two years), and there is a 75% pass rate, by 1989 there will be 4,779 certified medical oncologists (Table IV). This would be far beyond the best-estimate requirement and 30 over the requirement for 1990 based on a 60-hour week doing 60% oncology.
2. If a slightly larger figure for 1987 and 1989 is used, based on 310 first-year trainees, by 1989 the number of certified oncologists again would have exceeded the best-estimate requirement and be almost identical to the estimated requirement based on a 60-hour week doing 60% oncology (Table V).

Certainly it would appear that by 1990 there will be no deficiency of medical oncologists. The exact number of noncertified oncologists practicing medical oncology is unknown. Moreover, with improved education, more primary physicians and other oncologists would be administering treatment. Utilizing the data from the National Manpower Survey, there were approximately 200 more trainees than those found in the current study (Table VI).

TABLE IV. Projection of Medical Oncology Manpower Using Past Number of Eligible Candidates

Year	Candidate	Passed	Certified
1983	—	—	2,977
1985	750	682	3,659
1987	750[a]	560[b]	4,219
1989	750[a]	560[b]	4,779

[a] Estimates based on similar number for 1983 and 1985.
[b] Estimated 75% pass rate.

TABLE V. Projection of Medical Oncology Manpower Based on 310 First-Year Trainees Completing 2 Years

Year	Candidate	Pass	Certified
1983	—	—	2,977
1985	750 (registered)	682	3,659
1987	805[a]	603[b]	4,262
1989	805[a]	603[b]	4,865

[a] Estimate 310 per first year completing 2 years.
[b] 75% pass. The high pass rate in 1985 is not anticipated in the future.

TABLE VI. Total No. of Trainees in National Manpower Survey [6,9]

	Oncology-hematology	Oncology	Total
1982-83	542	366	908
1983-84	652	349	1,001
1984-85	609	370	979

Recognizing that there is some error in collection of data of this type and its interpretation, it is reasonable to assume that there will not be a deficiency of medical oncologists. Training in medical oncology should be of high quality, providing clinical investigation and career training for academic oncologists, of which there is stated to be a lack of [10]. In order to assure the quality goals of oncology, and in an attempt to meet an adequate supply of medical oncologists, it seemed appropriate to establish guidelines for future training in medical oncology. A position statement was prepared, endorsed by the Board of Directors of the American Society of Clinical Oncology and the Association of Directors of Medical Oncology Training Programs [7,8]:

1. "New training programs should be restricted to institutions with a demonstrated commitment to clinical and/or basic research. Purely clinical programs without a modern research component should be discouraged. To assure the quality of education, training should occur in institutions where the faculty write papers, participate in research, and have research grants."

Comment: With the vast number of clinical oncologists in practice, it is mandatory that basic and clinical research be expedited by providing qualified academic oncologists to develop new innovative concepts of diagnosis, treatment, and management.

2. "Discontinue programs currently without fellows. In the survey there were 7 such programs, 4 devoted to clinical training only."

Comment: Such programs are meaningless.

3. "Delete programs offering clinical training with only patient care delivery, but continue those offering clinical research. The academic model for the acquisition and pursuit of new knowledge requires a clinical investigative attitude. Patient care by the trainee should be a learning experience. The trainee should not be utilized to serve a patient load."

Comment: There were 18 programs with only clinical experience; 25 fellows were in these programs. One-trainee programs fail to provide good exchange of experiences between trainees. Programs that depend upon the trainee to take care of patients are "using" the trainee but not providing adequate training.

4. "Delete programs where more than 4 subspecialties of Internal Medicine and Radiation Therapy, Surgery and Pathology are not represented in the institution. The trainees require exchange of experiences with other specialties."

5. "To reduce U.S. manpower excess, good foreign trainees should be attracted to U.S. training programs, but with a commitment to return to their homeland to extend benefits provided by Medical Oncology."

Comment: Twenty percent of all trainees in fellowship training are either foreign medical graduates (FMG) or U.S.-FMGs. It is necessary that the United States extend its expertise to those countries in need of qualified oncologists.

6. "Require the rotation of Internal Medicine residents to Oncology services to improve their training in Medicine."

Comment: The cancer problem constitutes a major illness of the elderly, who make up an increasing part of internal medicine. Primary care physicians in internal medicine should be qualified to diagnose neoplastic diseases, teach prevention of cancer, and administer standard therapies accurately.

7. "Require more rigid definition of training programs in the combined Oncology-Hematology programs. There should be a clear definition of the separate training tracks and assurance of the quality of that training. Encourage combined programs to share experiences and facilities, but to maintain clear definition of the needs of each training track. The greatest proportionate increase (25%) in the number of entering fellows in all subspecialties between 1982 and 1983 was in these combined programs."[6].

8. "Focus on funding for academic programs. Training grants for fellows intent on research careers should be encouraged. There is a critical need to increase the academic oncology base to help translate exciting developments of basic research into clinical application."

Comment: Table VII tabulates the source of funding for the oncology and oncology-hematology programs [6]. The oncology-hematology programs received their greatest funding from hospital revenue and Veteran Administration programs, whereas the oncology programs received their largest proportion from state and local governments. Almost $24 million a year is devoted to training in these two types of programs alone. Reduction of Veterans Administration clinical training programs could be substantial, yet the Veterans Administration's Associate Program for research training should not be impaired.

9. "In order to meet the academic and research needs of Medical Oncology and provide mature oncologic physicians, 3-year training programs are needed."

Comment: In view of the expanding information in medical oncology and the need to develop academic oncologists, mandatory requirement of a 3-year training program in medical oncology would be advantageous. At least a minimum of 2 full years of pure medical oncology training should be required.

10. "Seek methods to encourage or force a reduction of the number of trainees in Oncology by directors of the programs, including the large programs. Obtain commitments from program directors for reduction of the number of trainees." It has been proposed, for example, that the number be reduced up to 50% over 5 years.

Comment: As indicated in the current survey, there appears to be no significant reduction in the forthcoming year of traineeships. The number of internal medicine fellowship training programs and the number of trainees is at an all-time high, suggesting that fellowship training is not being internally regulated to control the number of subspecialists needed to meet appropriate manpower needs despite a perceived oversupply of such physicians [9]. Despite the fear that an oversupply of subspecialists could erode the patient base that teaching hospitals need for teaching and research, the directors of the teaching hospitals and the subspeciality fellowship programs show

TABLE VII. Sources of Funding for Trainee Stipends in Oncologic Programs [6]

Source	Percent in oncology-hematology	Percent in oncology
Hospital revenue	32	19
State and local government	2	29
Veterans administration and military	26	8
Federal training grants	20	11
Foundation training grants	3	10
Total dollars (millions)	$15.788	$7.924

no inclination to reduce the number of subspecialists in training [6].

The Council of Subspecialty Societies of the American College of Physicians has prepared a statement on manpower regarding the concern of a surplus of subspecialty physicians. This statement includes (a) recognizing there is a need to reduce the number of training positions in the various medical subspecialties, (b) supporting efforts in Congress to reduce the number of foreign medical graduates entering training programs (but would encourage exchange visitors to return to their country of origin after training is completed), (c) limiting access to subspecialty training programs to exclude or severely limit access of U.S. citizens graduating from non-LCME-approved schools, (d) development of more complete guidelines that would be useful to the Residency Review Committee in establishing criteria for approval of training programs for the subspecialty, and (e) continuation of support of the National Study of Internal Medicine Manpower. The statement has been endorsed by the American College of Physicians [11].

The Impact of Medical Oncology

The explosion in the number of trained medical oncologists has helped bring necessary oncology expertise to the community, so that modern and competent care of patients with cancer is available outside the research and university centers. The availability of this care system has coincided with the improved survival rates and cure rates of several cancers. There seems little doubt that the new oncologists are bringing the fledgling science to the people.

Although initially trained to meet the need to apply the product of research in chemotherapy to the care of patients with advanced stages of cancer, the medical oncologist is developing research to better understand disease biology aimed at developing more effective treatments. The medical oncologist has become a symbol of the cancer specialist, expected to provide judgment in total management of the patient with cancer.

The increasing number of medical oncologists in the community has led to concern that clinical research at major research institutions will be altered. This is already true. With qualified oncologists in the community, the patient with cancer can remain closer to home and the cost is less. We can be proud of the accomplishment of improving the quality of community cancer care. Some regard these educational efforts as a self-destructive process of major medical cancer centers responsible for training and research. Certainly the methods of training and research will be altered. The research will be directed toward those cancers that still defy cure or even control. To stimulate the field of clinical research, training programs should include investigation as an integral and required part of training [10]. The medical oncologist in practice should continue to participate in clinical investigations.

The chaotic nature of change to which medical care is currently being subjected, adds difficulty in determining the exact manpower need. The increasing number of female oncologists changes the calculated lifetime productivity. Women may spend fewer hours in work per week, fewer years in practice, and possibly more time with the average patient. With the calculated productivity of female physicians to be 78% of their male counterparts, the surplus of oncologists might be revised downward. In contrast, no one can predict the impact that might occur on manpower needs if a significant discovery occurred in a major cancer in which the treatment process would require additional physicians in order to attain control or cure of that disease. Furthermore, the actual numbers of medical oncologists in practice may be altered by the increasing number of women as well as men who may wish for shorter hours, physicians undergoing "burn out" and abandoning the field, and attrition (which will be small). The oncologists certified in the past 12 years represent a young population of physicians and currently will lack the attrition by death that occurs in longer-established subspecialties such as cardiology.

A continuing awareness of the need for medical oncologists should be maintained so as not to surpass a reasonable number of skilled subspecialists. As the goal and numbers of clinical medical oncologists needed is being attained, the distribution must also be considered. This requires the recognition of the need in communities in order to aid the placement of the medical oncologists.

One of the most likely places for regulation will be the demand for medical services. As restraints are placed on medical services to reduce costs, the demand for oncology services may decrease [6]. Many consider the future of the physician pool to be a political question [12].

The health maintenance organizations (HMOs) are having a significant impact on national requirements for medical personnel. Projections based on the average experience of three HMOs suggest that 50% fewer primary care physicians for adults will be needed to meet national primary care needs in 1990 than projected by the GMENAC [13].

Oncology Growth

The medical oncologists assume a major responsibility for the care of the patient with cancer throughout the entire course of the illness. Of the existing clinical practice fields of internal medicine, the one that seems sure to grow is medical oncology. It involves team effort collaborating with radiotherapists, surgeons, and other health providers. Since medical oncology appears to have

TABLE VIII. Factors Favoring Growth of a Clinical Speciality [13]

Chronic disease
Good basic science correlations
Complex diagnostic technology
Variety of palliative measures
Third-party payment for procedures
Short-stay hospital care
Large volume of current literature in basic science, diagnosis, better palliation
Lack of simple curative treatment
Attractiveness of field

a long-promised future as judged by established criteria [14] (Table VIII), a careful ongoing assessment of the manpower needs is warranted.

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RESULTS OF THE FELLOWSHIP MATCHING PLAN IN ONCOLOGY

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Abstract – The Medical Specialties Matching Program provides a means for fellowship applicants and participating institutions to rank their preferences. The first attempt in 1986 resulted in a wide variation in the percentage of matched positions according to specialty. For oncology, the programs ranged near the median, ie, of 255 enrolled positions, 207 (81.2%) were actually offered. Of these, 148 (71.5%) were filled. In 76 programs, 61% of the positions were not filled. Oncology directors have expressed reluctance to participate in this Matching Program in the future.

Under the management of the National Resident Matching Program (NRMP), appointments in Medical Subspeciality Programs were selected for 1987. This instituted, for the first time, an approach for the selection of medical subspeciality fellows on a basis similar to that of selecting G-1 (ie, PGY-1) residents. The stated purpose of the Medical Specialties Matching Program was to allow all applicants seeking positions and participating institutions the opportunity to rank their preferences confidentially at a uniform date. The plan matches an applicant to the institution, which was ranked highest on the applicant's list, and which, in turn, had listed the applicant for a position. Only subspeciality programs in accredited Departments of Medicine could offer positions. The plan was conceived to give prospective subspeciality fellows more time to develop their interests in a subspeciality area and to apply without pressure from program directors to commit themselves to a training program.

In the fall of 1985, agreements were made available for the participation of applicants and subspeciality programs. The program agreements were submitted to the NRMP office by March 22, 1986. Program agreements and applicant agreements were received in the NRMP office by March 26, 1986. The following month the applicants and program directors prepared their rank order list. These rank order lists were due in the NRMP office by May 23. The results of the match were delivered on June 18, 1986.[1]

The Association of Medical Oncology Directors agreed in 1985 to support the program and encouraged the program directors to participate. It was anticipated that some problems would evolve, and it was known that a few institutions had already decided not to participate. Of the Chairman of Departments of Medicine who joined the matching program, not all were unanimous in their support. Various levels of participation were subsequently noted:

1. Divisions were instructed by departmental chairpersons to participate in the program.
2. Divisions were offered the option of participating or not.
3. Some programs listed a few positions in the matching program, but retained other positions for appointments outside of the matching plan program. These were termed "Swing positions."
4. A few Departments of Medicine chose not to participate.
5. Several cancer institutes did not participate.

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In March, 1986 there was concern about the many oncology programs that were not participating in the matching plan. A meeting of Medical Oncology directors resulted in the conclusion that the matching program was not progressing satisfactorily, and that diverse methods of appointment were in process. Most apparent was the lack of participation by the National Cancer Institute. Others, feeling competitive to that institution, did not choose to participate in the matching program. The matching program was regarded as a good idea—if *everyone* joined. Therein, was the problem. The meeting concluded with this proposal:

> That notice be sent immediately to all appropriate participants and agencies to establish early commitment for all available fellowship positions to be implemented as soon as possible effective with the 1988 match and for succeeding years.

In May, 1986 at the meeting of the Association of Medical Oncology Directors, the attitude of the directors was almost totally opposite to that expressed one year earlier. In favor of the program was the support of the applicants: the matching program provided interviewing and selection of a first choice without the pressure from a program director asking for immediate commitment to a fellowship. This was deemed to be an advantage for the applicant.

Opposition to the matching program expressed the importance of a commitment to quality research. The program directors stressed the need for selecting a fellow to fit into the areas of a division's ongoing research program. Those directors preferred to select individual candidates and negotiate a position. Others compared the selection of a fellow to that of selecting a new faculty person. That person is selected because of many merits that would be necessary to support an oncology program. Second choices are often not acceptable. Major defects in the matching program were expressed and included the lack of strong support by many professors of medicine, the non-participation of major cancer institutes, and the clear cheating in the system. The philosophical conflict in regard to participation or lack of participation in the matching program was that of institutional preference versus support of the applicant's interest; self-interest versus altruism.

RESULTS OF THE MATCHING PROGRAM

Analysis of the matching program results clearly indicates that not all subspeciality programs participated in the matching plan, and not all available positions were submitted to the matching program. Initially 1304, or three-quarters of the 1736 training programs listed in the Federated Council of Internal Medicine (FCIM) Directory, enrolled in the matching program. After withdrawals from the plan, participation was 68.6 percent.[1] The participating institutions listed 2,434 training positions, but in their Rank Order lists, only 2,073 positions were offered, a decline of 15 percent. Initially 2,694 applicants registered, but only 2,240 (83%) submitted Rank Order lists. The 454 withdrawals most likely were offered positions, and accepted positions outside the match. The General Internal Medicine programs had the lowest number of offered positions (39) in 22 participating institutions. Only 38% of those positions were filled.

The more popular specialties fared well in matching. Gastroenterology, Cardiology, and Pulmonary had a high percent of match, 93.4%, 92.3%, and 85.3%, respectively. The lowest percent of match was in Endocrinology-Metabolism (52.5%) and Nephrology (53%). In those specialties, along with Geriatrics, over 80% of the programs failed to fill their quota.

In Medical Oncology, 42 programs enrolled but 7 withdrew (17% decline). In Hematology-Oncology, 103 programs enrolled and 8 withdrew (8% decline). This represented 58.3% and 77.9% respectively, of the programs listed in the FCIM roster (Table 1). In Medical Oncology, of 35 enrolled programs offering 45 positions, 69% matched. It was apparent that the larger programs were

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Table 1. Oncology results in the Medical Specialties Matching Program (MSMP)

	Hematology/Oncology	Medical Oncology	Total
Number programs listed in FCIM Roster*	122	60	182
Enrolled in MSMP	103 (84.4%)	42 (70%)	145 (80%)
Enrolled after withdrawal	95 (78%)	35 (58.3%)	130 (71.4%)
Number positions enrolled	190	65	255
Positions offered (Rank Order list)	162 (85.3%)	45 (69.2%)	207 (81.2%)
No. of offered positions filled	117 (72%)	31 (69%)	148 (71.5%)

*Federated Council of Internal Medicine.

not participating. In the combined Hematology/Oncology programs, with 95 enrolled programs offering 162 positions, 72% matched. Combining these figures, 71.5% of the positions offered were matched. There were 0.9 applicants for each position. In all, 72% of Medical Oncology programs and 57% Hematology/Oncology programs failed to fill their quota. Combining these, 76 oncology programs were unfilled (61%). Of the 153 positions offered by these programs, 48 (31%) were not matched.

Comparison to the Oncology Training Program Registry

These results were compared to the data on available training positions previously accumulated in a Registry of Oncology Training Programs.[2,3] Of the 49 Medical Oncology Training Programs in the Registry, 35 (71%) enrolled in the matching program. In the 105 combined Hematology/Oncology programs, 95 enrolled (90%). Overall, of 154 Registry programs, 130 enrolled (84%). Apparently 28 programs made no effort to be listed in the Registry. Hence, data of those is not available—explaining the discrepancy in the number of total positions between the Registry and FCIM data.

In the analysis of the Oncology Registry, Medical Oncology planned to offer 150 first-year positions in 1986.[2] However, only 45 actual positions were offered for the matching program for 1987, 30% of the estimated first-year positions. In contrast, the combined Hematology/Oncology programs offered 162 (76%) of 213 planned positions. Totalling these two, of 363 potential first-year planned positions, 207 were offered for matching (57%). This comparison of two sets of data demonstrates that many more positions are available than were enrolled. Since four major institutions in oncology training did not participate in the matching program, at least 43 positions were not entered for matching. It is apparent that institutional participation was relatively low in the Medical Oncology programs.

DISCUSSION

The results of the matching program demonstrate a wide variation in the percent of matched positions in the various subspecialities. Gastroenterology, Cardiology, and Pulmonary did well, which reflects a popularity of those subspecialities. The Oncology programs ranged near the median.

It is apparent that approximately 25 oncology programs (ie, Hematology/Oncology plus Medical Oncology) did not participate in the matching plan. Approximately 33% of the oncology positions available were not listed by 15% of the available programs. Some cancer institutes did not participate. Although the number of programs in the FCIM roster and the ASCO Registry were different, the comparison of information emphasizes that many more training positions are available than were enrolled in the matching plan. In a poll of 16,000 men and women who graduated from U.S. medical schools in 1986, approximately 60 (0.4%) plan careers as basic or clinical scientists.[4,5] This implies that there will be increasing competition for a small supply of academic goal-oriented persons in Oncology, who are a major need.

The opinions expressed at the 1986 meeting of the Association of Directors of Oncology Programs – ie, ranging from favorable comments about the advantages from the applicants' viewpoint, to criticisms based on unique qualifications of only certain applicants for a specific position – would suggest that in the forthcoming year, Oncology programs are less likely to participate in the matching program.

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American Society of Hospital Pharmacists
4630 Montgomery Avenue
Bethesda, MD 20814

(301) 657-3000

November 9, 1987

Paul M. Schwab
Executive Secretary, Council on
  Graduate Medical Education
Health Resources and Services
  Administration
Parklawn Building
Room 14-05
5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Schwab:

The American Society of Hospital Pharmacists (ASHP) is the national professional society of pharmacists practicing in hospitals and organized health-care settings. As the national accrediting body for pharmacy residency programs, ASHP is concerned about the impact that the forthcoming recommendations from the Council on Graduate Medical Education would have to these programs; we welcome the opportunity to provide the necessary information to the Council to ensure that modifications to the current system do not adversely affect pharmacy education. Toward that end, ASHP is pleased to provide the Council with the following information about pharmacy residencies and their contribution to this country's health-care delivery system.

A pharmacy residency is a postgraduate program of organized training in the institutional environment. Its foremost objectives are (a) to provide practical experience to residents in the coordination of total pharmaceutical services within an institution and (b) to provide a broad range of in-depth experiences designed to advance the residents' level of knowledge and enhance their ability to promote new and improved pharmacy services.

The long-term cost effectiveness of graduate medical education is well established. In particular, the contribution of pharmacy residency programs to the nation's health-care system far exceeds its costs to the federal government. Most of today's institutional pharmacy leaders are graduates of residency programs; these exemplary practitioners are engaged in far more than traditional dispensing activities. They are responsible for such cost-effective pharmacy programs as implementing adverse drug reaction monitoring programs for patient safety, reviewing the therapeutic efficiency of prescribed medications, and fostering safe and effective utilization of modern pharmaceuticals. It is generally recognized that today's high level of patient-oriented pharmaceutical services in institutions has been made

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possible through the knowledge and skills that were acquired during the residency program. Today's pharmacy residents will become tomorrow's pharmacy leaders who will continue to make positive, progressive, advances in the delivery of high quality, cost-effective health care.

The contributions of pharmacy residency programs to the nation's health-care system in general, and Medicare beneficiaries in particular, far exceeds its short-term costs to the federal government and other third-party payers. A review of Medicare funding for pharmacy residency programs will demonstrate their cost effectiveness. In total, there are approximately 360 residents being trained in 125 non-government hospitals that receive Medicare funds. In 1986, the total cost to these institutions for providing pharmacy residency programs was $10,516,000.

However, this is not the total cost to Medicare. Assuming an average hospital Medicare population per hospital of 30 percent, the amount reimbursable to hospitals from Medicare for training pharmacy residents was only $3,154,800. Thus, the cost to Medicare for training pharmacy residents becomes minimal when compared to the cost for total funding of non-physician health professional training programs. In fact, our estimate is that institutional pharmacy residency training constitutes about one percent of the total cost to Medicare of health professional training.

Although pharmacy residency programs cost the federal government a very small amount of money, the elimination of those funds would cause severe damage to the existence of institutional pharmacy residency programs. A recent survey of ASHP's pharmacy program preceptors showed that 62 percent of these institutions would be forced to limit or eliminate their pharmacy residency programs if Medicare funding were terminated.

In this era of cost containment, the training of individuals who are committed to providing the best quality health care available in the most cost-effective manner has become critical. Consistent with this goal, ASHP urges the Council on Graduate Medical Education to consider the value of pharmacy residency programs to patient care as they finalize their recommendations to change graduate medical education program's scope and funding. Should you need any further information regarding this matter, please do not hesitate to contact us.

Sincerely,

Beverly L. Black

Beverly L. Black, Director
Management and Reimbursement Department

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ASSOCIATION OF PROGRAM DIRECTORS IN SURGERY

October 28, 1987

MAILING ADDRESS
1617 J F KENNEDY BLVD., SUITE 1561
PHILADELPHIA, PA 19103

Mr. Paul M. Schwab
Executive Secretary
Council on Graduate Medical Education
Health Resources and Services Administration
5600 Fishers Lane
Room 14-05
Rockville, Maryland 20857

Dear Mr. Schwab:

The Association of Program Directors in Surgery is made up of all directors of residency training programs in general surgery. This Association is organized primarily for the purpose of improving the quality of graduate surgical education. We appreciate the privilege of submitting a statement to the Council on Graduate Medical Education to be considered for the forthcoming public hearing.

The APDS wishes to go on record in support of the concept that graduate education in surgery requires a minimum period of five years following completion of medical school. Previous attempts to shorten the length of surgical training have not been successful. The complexity of the clinical practice of surgery and of the care of surgical patients are increasing rapidly. Surgical residents are expected to acquire not only the knowledge and the technical skill to master the care of surgical patients, but they must also acquire the clinical maturity and the judgment to allow them to function safely as independent practitioners. It is the development of this maturity and judgment that cannot be hurried and that makes the difference in the quality of care for surgical patients. In our view, this maturing process requires a minimum of five years of training, and sometimes requires more.

We, therefore, urge that the minimun period of surgical education be maintained at five years, and that reductions in this amount of time not be supported by COGME.

Thank you.

Sincerely yours,

Paul Friedmann, M.D.
President

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Statement Submitted to the Council of Graduate Medical Education

November 19, 1987 Public Hearing

by

Dr. Martin Dillard
Assistant Dean for Clinical Affairs
Assistant Medical Director Clinical Affairs
Howard University Hospital

Assisted by
Marilyn Johnson
Legislative Analyst
Howard University

Introduction

Thank you for the opportunity to present our views on subjects to be considered by the Council on Graduate Medical Education. The Howard University Hospital and College of Medicine, located in Washington, D.C., have a special mission to provide education to minority physicians and to provide medical care for indigent patients. Because of this we have a special concern about the supply and distribution of physicians in the United States and about current and future shortages or excesses of physicians. In the interest of presenting our concerns in a concise manner, this statement will concentrate on these two topics. We are also concerned, however, about the other issues being addressed by the Council. Consequently, we have included a copy of testimony on Medicare Financing of Graduate Medical Education submitted to the Senate Finance Committee on June 10, 1985 by Mr. Haynes Rice our Hospital Administrator and stand ready to provide any additional information your panel deems appropriate.

History

Congress first addressed concerns over the adequate supply of health professionals in the Health Professions Educational Assistance Act of 1963. This legislation provided comprehensive, federal funding assistance to qualifying students and medical education institutions. Because of testimony that a shortage of physicians continued to exist, Congress in 1970 passed Public Law 91-623, the Emergency Health Personnel Act. This legislation provided direct financial support for medical education in exchange for a promise to practice in health manpower shortage areas after the completion of training. Other legislation passed in the same era provided federal support for the health professions schools in financial distress and grant support for certain types of postgraduate training programs to physicians providing primary care. The results of these legislative acts was a dramatic increase in the number of physicians trained annually.

This rapid growth in the population of practicing physicians combined with the dramatic and persistent increase in health care costs have led to the current perception that there is an oversupply of physicians in the United States and that the national interest requires steps to control and perhaps reduce the number of new physicians being produced.

We would agree that increasing the total number of physicians may be detrimental to the overall medical profession. We also admit that, as practitioners, we are best served financially by action which would keep the supply of doctors low. We must, however, in this instance, speak on behalf of the consumer because of our special interest in providing medical care in areas populated by minorities and indigent patients.

The report of the Graduate Medical Education National Advisory Committee predicted a surplus of physicians in the United States by 1990. The major report did not address the need for minority physicians as a separate issue. An attempt was made to correct this oversight by a supplementary report but this report never received publicity and discussion which it deserved. Other studies examining the question of physician manpower are guilty of the same oversight including the one currently in progress under the direction of the American Medical Association.

Discussion

I. The Expected Effect of Current Policies and Present Trends on Future Physician Supply

The need to protect and even increase the numbers of minority physicians arises not only from questions of fairness and equity but also from evidence that minority physicians are more likely to practice in underserved areas and to accept indigent patients into their practice. A report of a survey done of graduates of the Howard University College of Medicine supports these statements and is attached for reference. There are other factors which we believe will also threaten the future supply of minority physicians and we would like to list these now.

A. Many of the persons who would have chosen careers in medicine in the past are now opting for more lucrative careers in engineering, law, computer science and finance.

B. Individuals formerly interested in helping mankind by setting up small, intimate practices, are forced by economics to try to acquire existing practices, join existing practices, or work in HMO's because it is very difficult and time consuming to build up large practices that can support the large medical education bills they have accumulated.

C. Reports of large malpractice suits and exuberant malpractice insurance rates are not only discouraging prospective students from entering the field, they are also forcing many practicing physicians to leave or change their fields.

D. Urban and rural areas are serviced by minorities and foreign medical graduates. Current policies are reducing the number of FMG's who are allowed to enter this country while, at the same time, fewer minorities are entering medical school.

E. Health care consumers are increasingly opting to take advantage of HMO's instead of health plans like Blue Cross/Blue Shield; thereby reducing the number of persons using non-participating public and private medical facilities.

II. The Effect New Technologies, Scientific Breakthroughs, New Diseases, and Demographic Changes Will Have on Manpower Needs.

In the past, new diseases were not likely to be a factor in the supply of medical personnel. This situation has changed drastically since the onset of the AIDS epidemic. This disease disproportionately affects the minority community. Also the long term cost of treating persons with this disease frequently forces them to require care for which they have no means to pay. Again minority physicians are most likely to provide the needed care.

Finally, we want to address this topic as it relates to the geriatric population. There is little question that in the next decade the focus of the nation's medical problem will be different. Millions of elderly citizens are living beyond the life expectancy of 10 years ago. Practicing physicians will, therefore, have to expand their knowledge and skills in order to adequately care for this sector of society. The increase in this population group with their documented need for primary care physicians underlines the need to assure that those members of the physician segment most likely to provide that care receive the public's encouragement and support.

III. The Impact Rising Medical Education Expenses Will Have on Prospective Students, Especially those from Underrepresented Groups

The costs associated with higher education have increased drastically in recent years. At the same time, federal student assistance has been reduced. Fears that education will again become an option for only the rich are fueled by these events. If it is true that persons are more inclined to pursue careers which bring a return on their investment in as short a time frame as possible, why would one be tempted in light of the other unfavorable circumstances we have highlighted with regard to the health profession to choose it?

More importantly, those persons for whom we have expressed particular concern (minority students and minority patients) are being doubly impacted by the current trends and are singled out in this text because they are least able to afford higher education, and least able to complete their training without special support. Many persons would advocate that the nation would be better served by ignoring that sector of the population and letting those persons better prepared for medical school occupy the limited spots which are available.

We ask to you, however, if those who are better prepared financially and academically likely to practice in a ghetto or rural hospital? And if by chance they ignore the fact that they need to make a lot of money to pay their educational bills, are they going to be as sensitive to and perceptive about the cadre of needs of patients living in those communities? Are they likely to teach in university-affiliated schools which have large minority student bodies?

History has indicated that they won't and information documenting the facts have been included in the paper presented by Mr. Sterling Lloyd our Assistant Dean for Student Affairs on September 25, 1987 which is attached for your review and consideration.

IV. Recommended Policy Changes in Public/Private Sectors Which Can Effectively Deal with Projected Imbalances in Physician Supply

Recommendations to increase the numbers of persons entering and staying in the medical field include a restructuring of the malpractice insurance statutes; a loan forgiveness program for any qualified medical student who agrees to work in an underserved area; the availability of public and private funding and technical assistance for persons wishing to start new practices; and, programs to encourage all qualified minority students to enter medical school. It is our premise, however, the most beneficial policy changes would surround those aimed at increasing the number of persons from traditionally underrepresented groups. Specific suggestions on how this can effectively be accomplished has been compiled by Sterling Lloyd.

Pre-College Recommendations

1. Improve science education for blacks at elementary, junior high, and high school levels;
2. Guide students in selecting appropriate courses and extracurricular activities for success in premedical curriculum;
3. Increase interest among blacks in medicine as a career;

4. Develop the academic skills needed for success in college, including reading, writing, quantitative, and oral communication skills;

5. Enhance test-taking skills required for success on standardized tests with emphasis on the SAT and ACT;

6. Install appropriate attitudes related to academic achievement, build self-confidence, and promote individual as well as group responsibility for learning and performance;

7. Involve parents, teachers, community leaders, colleges, universities, local physicians;

8. provide opportunities for students to develop and test their problem-solving and analytical skills;

9. Develop financial plans for meeting college and medical school costs, including scholarships, loans, and family contributions;

10. Guide students through the college application process for premedical education.

Undergraduate Education

1. Improve science education for blacks at the undergraduate level;

2. Promote interest in medicine as a career among black undergraduates who have not chosen science as a major;

3. Facilitate the transition between the high school and the college curriculum;

4. Offer summer programs for minority premedical students that will strengthen their motivation, fortify their academic skills, enhance their academic record, and generally improve their preparation for medical school;

5. Develop the academic skills required for success in undergraduate and medical school, including reading, writing, quantitative, and oral communication skills;

6. Enhance test-taking skills needed for success on standarized tests with emphasis on the MCAT;

7. Install appropriate attitudes related to academic achievement, build self-confidence, and promote individual as well as group responsibility for learning and performance;

8. Provide opportunities for students to develop and test their problem-solving and analytical skills;

9. Guide students through the application process to medical school;

10. Develop financial plans for meeting the costs of medical school, including grants, loans and family contributions.

Medical School

1. Improve the use of traditional measures--grades, MCAT scores, interviews, and letters of recommendation—in the selection of black students for medical school;
2. Identify and utilize useful non-traditional measures for selection of black students for medical school;
3. Expand pre-admission programs that yield qualified black medical school applicants, including post-baccalaureate and summer pre-matriculation programs;
4. Further develop academic skills needed for success in medical school, including reading, writing, quantitative, and oral communication skills;
5. Closely monitor academic progress and provide effective academic support programs;
6. Provide personal counseling and support involving peers, faculty and administrators;
7. Offer a curriculum that allows for additional time to complete degree requirements;
8. Enhance test-taking skills needed for success in medical school and postgraduate training with emphasis on the Natioal Board;
9. Guide students through the application process for postgraduate training,
10. Develop financial plans for meeting medical school costs, including scholarships, loans and family contributions, and provide counselling regarding loan repayment.

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Executive Director

TESTIMONY TO COGME

ON

November 19, 1987

The U.A.G. Alumni Association is an association of physicians who have graduated from the School of Medicine of the Autonomous University of Guadalajara. We were established in 1974 and have been active in promoting equal opportunity in training and licensure for foreign medical graduates ever since.

Frankly, when the appointments to the Council on Graduate Medical Education were announced, our Board of Trustees waited with some trepidation for the outcome of the first meeting. Our experiences with the Graduate Medical Education National Advisory Committee and with the GAO had not led us to expect open-mindedness and complete fairness in the discussion of issues surrounding foreign medical graduates in graduate medical education and licensure.

You can imagine the very pleasant surprise we received following the first public meeting of this Council. It became quite clear that, unlike GMENAC, this Council was not going to recommend immediate and sweeping changes in both the structure and funding of graduate medical education.

It was equally clear that this Council was not going to blandly follow old and well-traveled roads in order to come up with a slightly different re-hash of past policies.

Instead, the Council as a whole and this Subcommittee have turned with fresh and open minds to clearly define the problems which face graduate medical education and to make recommendations for approaches to solving those problems which combine practicality with achievability. These recommendations achieve one other milestone: They do not appear to favor any one particular constituency.

Foreign medical graduates have made multitudinous contributions to medicine in the United States. By and large, they have been well integrated into the fabric of American medicine, despite laws and regulations which are biased against them and frequent forms of not too subtle discrimination.

Although we are sure this Subcommittee has read and heard many statistics and reports both pro and con concerning the foreign medical graduate, we would like to mention just a few points for consideration which we feel are important.

We have all kinds of programs for minorities, from bilingual education to multi-language ballots in the voting booth, but we have failed to address the issue of health care for the non-English speaking citizen. One of the fastest growing groups are those who share Spanish as a native language.

A 1980 study by by the California Office of Statewide Health Planning and Development on integration of USFMGs into medicine in California found a very high degree of utilization of Spanish in direct patient care, a finding which was influential in the continuing of a special training program known as Fifth Pathway in that State. Internal surveys by this Association have found an equally high degree of utilization of Spanish in patient care among members of our organization on a nationwide basis.

How do you measure the benefit a patient derives from being treated by a physician who shares the same language or cultural background?

What of the contribution the FMG makes to the medical community? For assistance, we turned to the AMA Guide entitled Foreign Medical Graduates, 1986. Although they make up less than 25% of the physician population, 12.9% are in full-time teaching positions, compared to only 1.5% of U.S. educated physicians. An interesting anomaly is it not? Those same medical schools which discourage their teaching hospitals from accepting FMGs into residency do

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not display the same reluctance in appointing FMGs to faculty positions.

This same source indicates that FMGs make up 25% of those physicians engaged in full-time research - a percentage consistent with their share of the physician population.

There is no evidence that FMGs make poor residents. There is no evidence that FMGs provide shoddy health care. Indeed, what data there is available suggests that it is the U.S. educated physician who is more likely to be sued for malpractice, to be disciplined by his or her state medical board, or to have his or her license revoked.

The U.S. medical community is justifiably proud of the quality of medical care available in the United States. Let us not forget that FMGs have contributed to this excellence.

We appreciate the complexity of the issues which this Subcommittee has had to consider. You are to be congratulated on a concise rendering of this complex issue into clearly understood principles.

Unless there are substantive changes in the preliminary conclusions of the Council on Graduate Medical Education and its Subcommittees, our Association will support its final report.

Respectfully submitted,

Neil Aldoroty MD

Neil Aldoroty, M.D.
Chairman

Ted Switzer M.D.

Ted W. Switzer, M.D.
Chairman-Elect

Helen M. Baker
Executive Director

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P.L.A.S.M.A.

PARENTS LEAGUE OF AMERICAN STUDENTS OF MEDICINE ABROAD
A Non-Profit Organization
63 N. Lake Drive
West End, New Jersey 07740

Samuel N. Feinsod, M.D.
President

We appreciate the opportunity to present this testimony to the Council on Graduate Medical Education. We ask that it be considered as part of the public testimony at the Public Hearing of November 19, 1987.

When we reviewed the charge to the Council and the minutes of its past meetings, we realized that the Council is endeavoring to its utmost to fulfill in a most responsible manner the broad charge that has been assigned to it by the Secretary of Health and Human Services.

We applaud the committee members for their willingness to give so generously of their time and energies to this important assignment.

As President of the Parents League of American Students of Medicine Abroad, I want to assure you that while we plead the cause of foreign medical graduates, we do not intend that that cause be served at the expense of quality medical care in this country.

With this in mind, we wish to make the following recommendations to you:

1. Foreign medical graduates must have equal opportunity for access to graduate medical training in this country. No one can argue that admission to American medical schools is always granted to those who will make the best doctors. It is likely that because of this a considerable number of potentially superior doctors are denied access to medical education in this country. Those who are especially motivated seek training in other countries. When they return after earning their degree, they are entitled to be evaluated fairly when they apply for graduate training. If they are not, not only do they suffer great harm, but citizens seeking medical care here are deprived of their services.
2. In order to evaluate all applicants for graduate medical education by the same standard, it is imperative that the same examination be used to satisfy requirements for admission. The stubborn resistance to arguments that requiring a different examination of foreign medical graduates is discriminatory leaves us puzzled as to what the establishment is afraid of.
3. We are leery of proposals which suggest accomplishing a reduction of residency positions by replacing residents with nonphysician service providers.

We believe this would reduce the quality of care delivered. This is most likely to occur where there are large numbers of indigent patients.

On the other hand, replacing residents with full-time health professionals would result in appreciably higher costs than under present practice.

4. We believe that American citizens who study abroad and then return here for graduate training must not be deprived of that opportunity by non-citizen foreign medical graduates. To satisfy the United States' objective of providing training for exchange visitor physicians, we should set up programs with goals consistent with the needs of these applicants and paid for, whenever possible, by the countries of origin. When funds are not available in those countries, as in many third world nations, alternate grants should be provided.

In summary, I wish to state that we support all efforts to improve the efficiency of the health care delivery system in this country. We urge that you approach your task by evaluating carefully what each segment of the medical community has to contribute. When you do this without regard to who lobbies hardest, we are confident that you will agree that the foreign medical graduate should continue to play a significant role in our health care system.

Thank you for this opportunity to present PLASMA's views to the committee.

Samuel N Feinsod M.D.

Samuel N. Feinsod, President

SAN JUAN BAUTISTA
SCHOOL OF MEDICINE

November 13, 1987

Mr. Paul M. Schwab
Executive Secretary
Council on Graduate Medical Education
Health and Human Resources Administration
5600 Fishers Lane
Brockfield, Maryland 20857

Dear Mr. Schwab:

The San Juan Bautista School of Medicine appreciates the opportunity it has received from the Council on Graduate Medical Education to present a summary of its efforts to offer a solution to the shortage of adequate health care for the underpriviledged both in the United States and in the Commonwealth of Puerto Rico.

San Juan Bautista (SJB) is a young, developing institution established in 1979 as a non-profit corporation with five specific objectives:

*To offer a four-year program of excellent medical education and clinical training to students who will be able to perform the health services required by both the Island population and the Hispanic population in the United States.

*To offer a medical education with a focus on prevention and primary health programs.

*To establish a solid program of family medicine which will train and motivate physicians to improve the Island's health care and the health of the Hispanic population of the United States.

*To train medical students to solve emotional, environmental, nutritional and community problems.

*To offer qualified Puerto Rican students the opportunity of studying medicine in their own country thus avoiding the high economic and emotional costs of studying abroad.

The School is duly licensed by the Commonwealth of Puerto Rico and accredited by the Council of Higher Education. It has a formal affiliation with McGill University for faculty and student exchange programs and joint research ventures which will emphasize AIDS projects, tropical diseases, nutrition and primary care delivery.

Since its establishment, the School has conferred 247 medical degrees. Its graduates have been accepted in nationally accredited internship and residency programs in Puerto Rico and the United States. Around 72% of our students approved the Puerto Rico State Board Examination of April 1987. Additionally a total of 23 students have been admitted in advanced standing to the three LCME accredited schools in Puerto Rico.

San Juan Bautista is also satisfying a growing demand for medical studies which has been partially met by foreign medical schools. Each year hundreds of students must travel to overseas schools in Mexico, Spain and, increasingly, in nearby Caribbean countries where students face high tuition fees as well as travel and living expenditures which often do not reflect the quality of education. Once they return to Puerto Rico many of them cannot pass the State Boards or find it hard to adjust to the strict requirements of residency programs. San Juan Bautista offers the alternative of a first-rate education on the Island without the economic and social consequences of studying at foreign schools which often lack effective quality controls.

San Juan Bautista is currently seeking accreditation by the Liaison Committee on Medical Education of the American Medical Association and is in the process of implementing its recommendations. A visit by the Committee is scheduled for 1988.

In its efforts to seek national accreditation, the School is fully backed by the Commonwealth's department of health and its secretary, Dr. Luis Izquierdo-Mora. They believe San Juan Bautista is a valuable source of family and general medicine practitioners, sorely needed specialties in Puerto Rico's current health delivery programs aimed at the 2.2 million U.S. citizens who are Island residents and classified as medically indigent.

In a letter of support written by Dr. Izquierdo-Mora to Congressman Jaime B. Fuster which was printed in the enclosed copy of the Congressional Record (House of Representatives, 8-4-87), the secretary explained that traditionally in Puerto Rico general practice and family physicians have come from the ranks of foreign medical schools graduates. In fact, the latest available statistics on physicians in Puerto Rico (1982) reflect that 84% of general practitioners and 40% of family doctors are graduates of these schools.

The secretary went on to explain that recent changes in medical education have limited the number of physicians allowed to practice medicine in Puerto Rico and graduates of only seven foreign medical schools are now allowed to take the State Board Examinations. Currently the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) is a requisite to take the Puerto Rico State Boards.

Although these changes were certainly necessary to uphold a high standard of quality care, the fact remains that the public health system now needs even more qualified general and family physicians and the traditional sources for these doctors have narrowed down.

Since San Juan Bautista is currently emphasizing family medicine in its curriculum, many graduates are choosing family or general medicine as their career choice thus making the School a valuable source of these needed specialties at a crucial point in the Island's health delivery efforts.

U. S. HISPANIC POPULATION

As stated in its objectives, SJB seeks to improve, not only the health of the residents of Puerto Rico, but also to make a definite contribution to the betterment of the health of U. S. Hispanics, currently estimated at around 8% of the population and expected to double in size within 25 years.

Because of cultural and language bonds, SJB graduates are in a unique position to help this group which, according to all available reports, still lacks adequate and comprehensive medical care. In fact, a health and human services task force concluded in 1985 that 60,000 more blacks and other minorities die in the U. S. than would die if they had the same age-adjusted death rates as other groups.

Numerous studies attribute much of this disparity to the lack of access of minorities to adequate health care. The same studies show that the largest number of health professionals serving blacks and other minorities were indeed minority health professionals. A 1985 New England Journal of Medicine article on affirmative action in medical schools (Keith SN, .et al, NEJM, December 12, 1985) reported that minority graduates were twice as likely to be practicing in underpriviledged areas than their non-minority counterparts. It is precisely in this area that SJB graduates can make a definite contribution. Since there is a clear tendency for SJB graduates to seek post-graduate training opportunities in the United States and because of language and cultural similarities, they have a definite advantage and could conceivably prompt more members of this minority to seek adequate medical care.

This assumption finds support in a number of studies that show that the ethnic make up of the patient population often reflects the ethnic background of their physician.

For example, the above-mentioned New England Journal of Medicine article explained that, in their sample, Hispanic patients represented a greater proportion of patients seen by Hispanic physicians than by any other racial or ethnic group of physicians.

MINORITY MEDICAL EDUCATION

A review of minority medical education in the U. S. points to the fact that Federal Government attention has been primarily directed at institutions that have been training black health professionals. Even with the growing trend of Hispanic population size and lack of regular health care, this group is dramatically underrepresented in U. S. medical schools with a 2.4% enrollment which is declining.

Two reasons are cited for this. First, is lack of money. Even when Hispanics are indeed accepted at some of the best medical schools, in many cases they simply cannot afford to attend. Another important fact is that while there are several black medical schools in the nation, there are no Hispanic schools in the U. S. mainland.

In Puerto Rico we can offer a solution to this growing problem. San Juan Bautista, in particular, is in an ideal position to fill the existing need for Hispanic general and family physicians but we need help.

First, we must [illegible] national accreditation to assure our students a [illegible] commitment to excellence in medical education. Accreditation would also ease access to accredited residency programs [illegible] in Puerto Rico and in the U. S. and would help our students qualify for federal government financial assistance that would enable more qualified applicants from low socioeconomic backgrounds to pursue medical careers.

However to complete the strict Liaison Committee requirements, we need Federal Government assistance. We have taken our petition to Congress and received a favorable reaction from Congressmen Richardson (D-N.M.), Waxman (D-California) and Fuster (Puerto Rico) (see Congressional Record House, 8-4-87). In fact, Congressman Waxman who is also the Chairman of the Sub-committee on Health and the Environment, acknowledged his intention to address the health needs of the Hispanic population by fostering the training of increased number of Hispanic health professionals when Title VII of the Public Health Service Act comes up for review. We also want to present our request to this Council for one time start-up funding of $1.3 million to improve our facilities and equipment, an area to which the Liaison Committee has assigned top priority and on which the School is working diligently.

The request is similar to the start-up assistance given by the Federal Government to the Morehouse School of Medicine in Atlanta, the first predominantly black medical school founded in this century. The assistance helped add much-needed facilities and plan a four-year program that led to accreditation.

CONCLUSION

Summing up, it is our feeling that the San Juan Bautista School of Medicine is in an excellent position to help improve the health needs of U. S. citizens who are residents of Puerto Rico. While it could be argued that the supply of physicians in both the U. S. and Puerto Rico could theoretically handle the needs of the population, the fact remains that the existing distribution of medical manpower leaves a considerable segment of our citizens without adequate medical care. The government of Puerto Rico has conceived a plan which addresses this problem and relies on SJB students and graduates for successful implementation.

In the U. S., minorities continued to be underserved. Conceivably, as studies point out, health care for this group could improve by increasing the pool of available minority physicians. While considerable attention has been given to the problems of the black population, it is felt that the growing Hispanic group merits special consideration to avoid what could become a critical problem of public health. The nation needs more Hispanic physicians to work with the growing Hispanic population.

The bilingual graduates of San Juan Bautista School of Medicine, many of whom are currently serving this group, could make an increasingly meaningful contribution to the improvement of the health of the nation's Hispanics. There is an added benefit for this growing minority. By having more Hispanic doctors available for treatment, their freedom to choose their physician would be enlarged thereby upholding what has been a guiding principle of U. S. health care delivery.

Cordially,

Juan

JUAN A. CHAVES ABREU
President

lao

Enclosure

WRITTEN TESTIMONY TO COUNCIL ON GRADUATE MEDICAL EDUCATION

For: Public Hearing, November 19, 1987

From: Society of Teachers of Family Medicine

The "Supply and Requirements for Family Physicians" (Dr. Marjorie A. Bowman, June 1987) and the "Financing of Training Programs for Family Medicine" (Dr. Jack Colwill, September 1987) have been reviewed before the Council on Graduate Medical Education. This written testimony will reiterate various findings by these individuals and present conclusions based on those findings.

1. Family physicians/general practitioners have not increased at the same rate as other specialties because of limited numbers of training positions. Between 1975 and 1985, the total number of family physician/general practitioners increased by 23 percent while total physicians increased by 40 percent and physicians in internal medicine increased by 66 percent. If current trends continue, the percentage of all physicians who are general/family physicians will remain at the current level of 12 percent of the physician population.

2. Family physicians are distributed better geographically in relationship to the overall population than are other specialists. Thirty percent of family physicians practice in nonmetropolitan counties (non-SMSA) compared with 11 percent of all other physicians. About half of family

practice resident graduates stay in areas with less than 50,000 population.

3. Family physicians are in great demand. This demand seems particularly strong both in developing organized systems of health delivery as well as in rural areas. Some estimate conservatively that there are at least three times the number of positions available as graduating residents.

4. Medical student interest in family practice remains strong. Ninety-six percent of residency positions are filled and only 12.9 percent of positions are filled by foreign medical graduates (compared to 16.8% for all specialties).

5. Recently trained family physicians have a different scope of practice from that of the former general practitioner. Residency trained family physicians continue to serve all ages and both sexes and continue to be distributed better in relationship to the overall population than other specialties. However, they spend more time with each patient, more time in preventive care, more time in counseling and less time in surgical procedures than their predecessors.

6. The precarious funding of family practice education jeopardizes the potential future supply of family physicians. Funding difficulties relate both to the reduced income potential of primary care and the amount of education in the ambulatory setting where training is inherently less efficient and more costly. Approximately one-third of program costs must be met through government support. The current plateauing of

residency positions in family medicine results from a plateauing in governmental support at both the state and national level.

CONCLUSIONS

1. There are insufficient numbers of family physicians in relationship to the physician population and to the needs of the American public.

2. There should be expansion in residency positions for family practice with appropriate funding.

3. Incentives must be provided to assist hospitals/institutions in expanding residency education in family medicine. These should take the form of:

   A. Enhancement of training grants under Title VII of the Public Health Service act for family practice residency programs.

   B. Increased Medicare reimbursement for residency education in family practice in relationship to other specialties which are in surplus.

   C. Incentives to states to initiate or expand state support for residency education in family practice.

4. COGME should investigate the impacts of the oversupply of physicians. An oversupply of physicians can encourage geographic diffusion of physicians thus increasing access to care. Potential negative effects of a physician oversupply are: insufficient procedures per physician to

maintain competence; increased iatrogenic disease; increased costs; possible physicians practicing outside of the area of their training; and possible encouragement of unethical behavior on the part of the physicians. Certainly, at some level, more physicians will add little to improving the health of the American people, i.e., decreased return for the input.

MEDICAL COLLEGE OF WISCONSIN

Mahendr S. Kochar, M.D.
Associate Dean

Office of Graduate Medical Education

October 8, 1987

Mr. Paul M. Schwab
Executive Secretary
Council on Graduate Medical Education
Health Resources and Services Administration
5600 Fishers Lane, Room 14-05
Rockville, MD 20857

Dear Mr. Schwab:

I would like to offer the following written testimony for consideration by the Council. My comments pertain to the issue of foreign medical graduates.

1. Many of the foreign graduates who were born outside of the United States and have now become U.S. citizens have excelled both in the practice of medicine as well as the academics. Many American Nobel laureates in medicine have been foreign born and graduates of foreign medical schools and many American born Nobel laureates were trained by foreign graduates. I am myself a foreign graduate and now serve as Associate Dean for Graduate Medical Education at the Medical College of Wisconsin. There is no evidence whatsoever that those foreign graduates who have gone into practice perform worse than the American graduates or have more malpractice suits against them. In many instances patients prefer foreign medical graduates over American graduates because they claim that foreign graduates listen to them more and are more humane in their approach.

2. Although the AMA and AAMC are generally unenthusiastic about foreign graduates receiving training or settling in the United States, it is in the interest of the American public that the doors be kept open for the foreign graduates to seek training and even settle in the United States. I believe that the current ECFMG and FLEX examinations guarantee that only the best foreign graduates receive graduate medical training in the United States and it is not necessary to create further obstacles in their path.

3. Foreign graduates who return to their countries of birth often refer patients back to the United States for medical care when it is not available in their home countries. This generates

foreign exchange for the U.S. As the economy of the United States shifts from a manufacturing to a service economy, these referrals help generate foreign exchange for the country.

4. Foreign graduates often enter graduate medical education programs that happen to be less desirable to the American graduates at any given time. This used to be the case with Physical Medicine, Psychiatry, and Anesthesiology in the '60s and '70s, and now is the case with Pediatrics and Internal Medicine. Currently more than 30 per cent of the board certified anesthesiologists, psychiatrists and physiatrists in the United States are foreign graduates. Many foreign graduates in these specialties are considered the very best in the field.

5. Unfortunately, the issue of foreign graduates is being politicized and I urge the Council to look at it objectively from the point of view of the American public, which is rapidly aging and would require humane and low tech care as opposed to the procedure-oriented high tech and expensive care that attracts the American graduates. As the cost of medical education rises, the number of applicants to the U.S. medical schools is falling. This in itself is a good enough reason to keep the doors open for the foreign medical graduates.

America has come to be what she is because of her highly motivated, hard working immigrants who have come to this land seeking greater opportunities and, in turn, have added to her glory. It would be inappropriate to shut off or diminish this infusion of brain power into the United States.

Sincerely yours,

Mahendr S. Kochar

MAHENDR S. KOCHAR, M.D.
Associate Dean

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September 25, 1987

Mr. Paul Schwab
Executive Secretary
Council on Graduate Medical Education
Health Resources and Services Administration
5600 Fishers Lane, Room 14-05
Rockville, Maryland 20857

Dear Mr. Schwab:

In response to your notice of the public hearing of the Council on Graduate Medical Education, I am enclosing a reprint of an article addressing issues in gastroenterology including the manpower issue. The relevant areas have been highlighted for easy reference.

If I can provide additional information, please contact me.

Sincerely,

BFOverholt

B. F. Overholt, M. D.

BFO:mb
Enclosure

Presidential address 1984

Gastrointestinal endoscopy in the 1980s: cost, challenge, and change

Bergein F. Overholt, MD
Knoxville, Tennessee

I could devote my time today to reviewing the remarkable progress of the American Society for Gastrointestinal Endoscopy in the areas of research, training, education, socioeconomics, and practice as they relate to gastroenterology and gastrointestinal endoscopy. Instead, I feel compelled to address the profound changes that are occurring in the arena of health care. State and federal governments, business, third parties, and even our patients are no longer willing to finance the rapid expansion of health care costs. They are projecting a clear message that, although quality and accessibility are desirable, cost escalations that have occurred recently will not be tolerated. We in medicine must be willing to listen to what is being said and to respond with positive leadership and change. Based on this background, I have chosen to discuss the subjects of cost, challenge, and change as they relate to our specialty. I will finish with six recommendations that address the following areas: (1) office endoscopy, (2) endoscopic fees, (3) primary endoscopy, (4) fellowship positions, (5) practice management and negotiations, and (6) quality of care.

Let me first address the issue of costs. It is estimated that total health care costs for 1982 reached the staggering figure of $322 billion, representing 10.5% of the gross national product.[1] Over $600,000 is spent for health care every minute. Government, third parties, industry, and patients believe these cost increases are excessive. They will exert tremendous pressures to restrain increasing health costs. Clearly the issue being addressed is cost, not quality.

Government has reacted to the rapid increase in health care costs by passing the Tax Equalization and Fiscal Responsibility Act (TEFRA) and Diagnosis Related Groups (DRG) legislation, designed to constrain hospital costs. Physicians, however, are beginning to receive their share of attention. Senator Dole has stated that "this is the year of the physician." Furthermore, for hospitalized Medicare patients, Senator Durenberger has stated: "Hospital and physician payments under Medicare must ultimately be lumped together."

Industry and third parties are also focusing on health care costs and are developing alternative health delivery systems, including the currently popular HMOs and PPOs in order to restrain costs.

Let me now turn specifically to our specialty. Gastroenterology and gastrointestinal endoscopy costs represent only a very small portion of the total health care costs. Our numbers of physicians are few, but because of the technology we use and the costs generated, we receive an inordinate amount of attention both from within and from without the profession. Almy[2] has extrapolated that a gastroenterologist's net hourly income for upper gastrointestinal endoscopy is over six times that obtained from the general management of the patient's illness. Based on a cost analysis for upper gastrointestinal endoscopy (EGD) in 1981, I stated that "in the hospital where the physician has no overhead or perhaps only the instrument cost to consider, a (physician's) fee of $250 to $300 would appear . . . to be excessive."[3] Schowstack and Schroeder[4] determined the cost per EGD including the physician's fee to be approximately $41 to $83. Although these authors have revised their estimates, the point to be made is that endoscopic fees are visible, controversial, and being scrutinized as one part of the total costs of health care. Now is the time for gastroenterologists to turn the "scope" around to view the health care we are providing with an eye toward providing care for patients in the best possible way at the lowest reasonable cost.

Although data covering the costs of gastrointestinal endoscopy are difficult to obtain, certain information is available. The frequency of performance of endoscopic procedures deserves comment first. Data com-

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piled through 1982 and projected for 1983[5] are presented in Table 1.

Although of equal importance, the subject of numbers of endoscopic procedures and the problem of overutilization is greatly overshadowed by the issue of costs of endoscopy. If one assumes an average physician charge of $275.00 for EGD and $400.00 for colonoscopy, the magnitude of the problem begins to take shape:

	Number		Charge*	=	Total cost
EGD	625,000	×	$275.00	=	$171,875,000.00
Colonoscopy	205,000	×	$400.00	=	$ 82,000,000.00

* Estimated

Adding the multitude of additional diagnostic and therapeutic endoscopic procedures and their associated hospital facility usage charges obviously raises the total costs of endoscopy to even more significant amounts. Total costs are viewed by government and third parties as figures of great significance, but it is perhaps of greater importance to review the wide variations of endoscopic utilization and charges between regions of the country and the remarkable variations within those regions. Data[6] from individual Medicare intermediaries representing geographic areas are outlined in Tables 2 and 3.

The tremendous variation between and even within regions in my opinion provides some evidence of excessive physician fees for endoscopy. I believe that the majority of endoscopists strive to keep prices within reason, but there remains a small percentage of endoscopists who charge excessively. Furthermore, I find no logical explanation for the wide range of fees within and between regions of the country even when cost of living variations are considered. My concern is that the large fees being charged by a few reflect financial interests and have very little to do with quality of care. I believe those physicians who charge excessive endoscopic fees not only tarnish the professional image of the majority of reasonable endoscopists, but, importantly, create an opportunity that can be exploited by regulators and others to essentially threaten the future of the specialty of gastroenterology and gastrointestinal endoscopy.

Table 1.
Numbers of endoscopic procedures from 1979 through 1983.[5]

Year	EGD (% increase)	Colonoscopy (% increase)
1979	465,000 (+12)	143,000 (+3)
1980	520,000 (+12)	163,000 (+14)
1981	535,000 (+3)	172,000 (+6)
1982	580,000 (+8)	190,000 (+8)
1983*	625,000 (+8)	205,000 (+8)

* Projected.

Table 2.
Frequency and cost of esophagogastroduodenoscopy per geographic region.*

	Frequency	Cost ($)		
		Low	Mean	High
West Coast	2,112		392	
Southeast	1,457	325	350	425
Mid Atlantic	12,738	150	318	900
West Midwest	741		275	
Central Midwest	2,464	225	350	600
Northeast	1,240	145	265	344

* Data from individual Medicare intermediaries.[6]

Table 3.
Frequency and cost of colonoscopy per geographic regions.*

	Frequency	Cost ($)		
		Low	Mean	High
West Coast	824		485	
Southeast	611	500	525	600
Mid Atlantic				
West Midwest	330		350	
Central Midwest	1327	250	450	650
Northeast	672	300	414	550

* Data from individual Medicare intermediaries.[6]

Let me now turn to the issue of manpower.[7-9] In internal medicine, residency positions have increased 23% or 3522 positions from 1976–77 through 1982–83. In gastroenterology, fellowship positions during this period increased from 755 to 772.

During the 20-year period from 1963 to 1983 the number of gastroenterologists increased from 564 to 4820, an increase of 854% which represents the single largest percentage increase in the medical subspecialties. In 1963 this represented one gastroenterologist for approximately 341,000 Americans, whereas in 1983 the ratio has shrunk to one for approximately 49,000. Increasingly, complaints about "too many" are being heard. These new gastroenterologists will vie for the shrinking patient population and will successfully compete with teaching hospitals for patients, with possible detrimental effects on training programs. It would appear that gastroenterology program directors must assess the future impact of the continued expansion of the numbers of gastroenterologists. To shirk this responsibility may well lead to major problems for teaching hospitals. I suggest that gastroenterology program directors consider eliminating a full-time fellowship position and offering it in the form of a "mini-fellowship" to practicing gastroenterologists who wish to update their clinical knowledge, thereby satisfying the work load needs, improving "town and gown" relationships, and ascertaining a continued referral base of the complex cases that fit so well into the teaching environment.

Change and challenge in gastroenterology and gastrointestinal endoscopy are occurring. The need for cost reduction is clearly the driving force behind what has, is, and will occur. Gastroenterologists have an opportunity now to participate, to lead, and to make the changes that will occur, or we can passively let government, third parties, and business do it for us. Now is the time for clear thinking and decisive action by our profession with an eye toward preserving the future of our specialty and the quality of care we provide for our patients.

What can be done? Let me discuss changes that in my opinion can accomplish stabilization or reductions in costs as they relate to our specialty and yet maintain quality.

Office endoscopy. Shifting more endoscopic procedures to the qualified physician whose office meets the facility criteria developed by the A/S/G/E will significantly reduce facility costs. Currently, only 15 to 20% of our membership perform office EGDs and colonoscopies. However, a trend toward more office endoscopy is developing which will place those physicians with this capability in a significantly better competitive position while also improving their practice efficiency.

Concerns about overutilization, performance by untrained physicians, and additional overhead have been raised by many. In my opinion reimbursement policies should be developed to limit reimbursement to physicians who have comparable privileges in their community hospital, similar to policies for reimbursement in ambulatory surgery centers. The potential for malpractice claims should discourage untrained and ill-equipped physicians from performing endoscopy in their offices. Peer review by peer review organizations and third party payers will impact upon the problem of overutilization.

Regarding the additional overhead, third parties are recognizing the significant cost savings potential of office endoscopy compared to hospital inpatient or outpatient endoscopy. Illinois Blue Cross/Blue Shield, for example, has achieved significant endoscopic cost reductions by reimbursing a "tray fee" for office endoscopy. I quote from a recent letter from the National Blue Cross/Blue Shield Association referring to office surgery, "Almost every Blue Cross and Blue Shield Plan is encouraging greater use of the physician's office instead of more costly facility settings for many surgical procedures. Approximately 42 Plans that underwrite medical-surgical care, currently provide some tray or set-up charge in addition to the physician's allowance for the surgical procedure."[6] Reimbursement to compensate for the additional costs of providing office endoscopy will soon be available to most endoscopists.

Endoscopic fees. In my opinion, endoscopic fees should be stabilized and in some situations reduced. Those endoscopists who charge excessively should reduce their fees. Furthermore, technology in endoscopy has improved rapidly but certain procedures, such as EGD and colonoscopy, have become more or less standard, require less time, and are associated with less risk than when initially introduced. Fees should reflect these factors.

Endoscopic fees should be based on a cost analysis modified by the risk, time, training, and malpractice premiums required to perform the procedure. To ignore this approach may result in the exclusion of at least some excellent endoscopic care as we enter into an era of fixed payment reimbursement for health care.

Primary endoscopy (PRIDGE). Endoscopy provides a better diagnostic study [illegible] compared to routine x-ray examination of the stomach. However, the greater cost of an EGD is a significant deterrent to the greater utilization of endoscopy as the primary examination of the upper gastrointestinal tract. To improve the quality and the cost-effectiveness of endoscopic care, endoscopists should consider reducing endoscopic fees for routine examinations of the stomach to ranges competitive with routine barium examinations of the stomach, which is the basis of the primary endoscopy or PRIDGE concept. To this end a new CPT-4 code has been adopted by the AMA that will allow incorporation of this procedure into the practice of gastrointestinal endoscopy.

Fellowship positions in gastroenterology. The rapid increase in the numbers of gastroenterologists may well have long range consequences that will negatively impact on teaching programs in gastroenterology. Likewise, the increasing numbers of gastroenterologists entering practice will drive health costs up even further and may well generate an unhealthy environment among practitioners. It will require strong leadership for program directors to alter the numbers of fellowship positions, but in my opinion it will be a necessary move to ensure the highest standards of training and practice in gastroenterology.

Practice management/negotiations. Today's gastroenterologists must aggressively orient their practices to serve the needs of their patients, including the needs of the elderly. Innovative thinking and practice styles will be exercised by some and they will be the successful gastroenterologists of tomorrow. Today's gastroenterologists must also become knowledgeable about the costs of providing a service for we are entering an era in which negotiations of costs and charges will become increasingly important. To negotiate without knowledge of the subject is paramount to losing before starting.

Quality. It is essential that gastroenterologists continue their efforts to ascertain the highest quality of care in medicine and gastroenterology. This requires active involvement in utilization review and peer review whether initiated by the profession or by other parties. No other group outside of the medical profession is more qualified to do so, nor does any other group have the interests of patients as its top priority.

In closing, these are times of dramatic change in medicine and gastroenterology. We have an opportunity to participate and to lead, locally and nationally, or we can simply be an observer as others dictate the change. It is our choice.

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